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Person of the Issue
Melanie Klein (1882-1960)

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At last, our thanks go out to the members of the journal who have done their best to work at this collaborative effort. May you continue in this wonderful spirit, which, we are sure will sustain your efforts in the future towards enhancing and enriching this journal.

Prof. Suresh Makvana[1]
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Person of the Issue: Melanie Klein (1882-1960)

Ankit Patel[1]*

Born	30 March 1882 Vienna, Austria-Hungary
Died	September 22, 1960 London, United Kingdom
Citizenship	Austrian
Known for	Devising therapeutic techniques for children Coining the term 'reparation' Klein's theory splitting Projective identification
Influences	Sigmund Freud Karl Abraham
Influenced	Herbert Rosenfeld Otto F. Kernberg Jacques Lacan Cornelius Castoriadis Donald Meltzer

Melanie Klein was born on March 30, 1882, in Vienna, Austria. In 1903, she married Arthur Klein and relocated to Budapest. They had three children, born in 1904, 1907, and 1914.

Klein's first personal experience in the field of psychoanalysis began when she sought treatment for herself after her mother died in 1914. Earlier in her youth, Klein's siblings died: her brother died when she was 20, and her sister died when Klein was 4 years old. Klein was in treatment with Sandor Ferenczi between 1914 and 1917.

Klein was a pioneer in the treatment of children. She was among the first to use psychoanalysis on children and implemented several never-before implemented techniques and tools. She often used play and toys to help children discuss psychological issues.

Klein's approach to psychoanalysis conflicted with much of Sigmund Freud's work. Freud drew his ideas on child development from the recollections of his adult patients, but Klein worked directly with children and toddlers, giving her unique insight into the child development process. She defied Freud, arguing that the superego is actually present the moment a child is born,

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preceding the Oedipal complex. Klein also claimed that a primitive form of the Oedipal complex was present much earlier in development than Freud claimed, as a child becomes preoccupied with overwhelming parental authority.

Her early work led her to certain clinical discoveries. For instance, she saw that the splitting appears very early as a mechanism in the child's mind, and that the mechanisms of projection and introjections accompanying the splitting result in the creation of a very complex internal world, even in a very small child. She saw the importance of early part-object relationships, already noticed by Abraham but never deeply investigated. As I have said, she had described both an earlier concept of the Oedipus complex and the roots of an early, very savage, superego connected with part-object introjections. But it was only with her description of the depressive position that Klein's early discoveries could be brought together to give a picture of the child's mental development.

However, there was yet another discovery to come, in the last years of her life. This is the discovery of the crucial importance of primitive envy, and this has become extremely controversial, even amongst some who agreed with Klein's theory of the two positions. It seems that the thought that envy could be early and primary, and directed from the start at the maternal breast, under the aegis of the death instinct, was an idea hard to tolerate. Envy is very connected with the pathology of the paranoid-schizoid position. Hatred attacks the bad object, but envy is directed at the ideal object, and interferes with the original splitting which enables the infant to have an ideal object, which is the basis of what in the depressive position becomes a more integrated good-and-bad object. Since it is the ideal object that is attacked in envy, it leads to a constant confusion between what is good and what is bad, and endless, often psychotic, confessional states. In the depressive position, excessive envy makes reparation very difficult, both because of the magnitude of the guilt, and because the object, once repaired, becomes again an object of envious attacks.

Since Klein, a great deal of work has been done by her pupils and followers on the transition between the paranoid and the depressive position, and the important role that is played in its pathology by the factor of envy.

TIMELINE

1882

- Melanie Reizes is born on 30th March at Tiefer Graben 8, Vienna to Moriz (aged 54) and Libussa Reizes (née Deutsch, aged thirty). Her father Moriz comes from an orthodox Jewish family from Lemberg, Galicia (now Lvov, Ukraine), and her mother from Warbotz, Slovakia. Moriz trained as a doctor against his very conservative family's wishes; Libussa is an intelligent, attractive young woman.
- Melanie is the last of four children, joining six-year-old Emilie, five-year-old Emmanuel, and four-year-old Sidonie. The family moved to Vienna from Deutschkreutz, Hungary (now Burgenland, Austria) sometime between 1878 and 1882.

1885

- When Melanie is three years old, Sigmund Freud, now 29, is in Paris studying hysteria and hypnosis with famous neurologist Jean-Martin Charcot.

1886

- Melanie's closest sister Sidonie dies of scrofula (tuberculous cervical lymphadenitis) at the age of eight. Melanie is four years old.
- Freud leaves Paris and returns to Vienna.

1887

- The Reizes family inherits a considerable sum of money on the death of Moriz's father. Melanie now five years old, the family moves from their second home in Vienna, a shabby fifth-floor apartment in Borsegasse, to a much larger, more elegant apartment in middle-class suburb Martinstrasse.

1891

- When Melanie is nine years old, 35-year-old Sigmund Freud moves to Berggasse 19, Vienna, his home and consulting rooms for the next 47 years.

1895

- In the same year as his last child Anna is born, Freud publishes his seminal Studies on Hysteria.

1898

- At the age of 16, Melanie already has her sights set on studying at the gymnasium. She has long wanted to study medicine, now specifically psychiatric medicine. This year she passes her entrance exams.

1899

- At the age of 17, Melanie meets her future husband, Arthur Stevan Klein, four years her elder and a second cousin. Klein is studying to be a chemical engineer in Zurich. He proposes to Melanie soon after their first meeting; she accepts. The engagement spells the end of Melanie's medical ambitions.

1900

- Melanie's father, Moriz Reizes, dies on 6th April at the age of 72. On 25th December, her eldest sister Emilie marries Leo Pick, a young doctor.
- Freud publishes his fundamental work, The Interpretation of Dreams. Freud is to maintain throughout his life that it is his most important work of all. It forms the keystone of psychoanalytic thought and practice.

1901

- Melanie spends the summer with the Kleins in Rosenberg (in Slovakian Hungary, now northern Slovakia) while Arthur is in America.
- Freud publishes On Dreams, a text which will critically influence Klein's psychoanalytic thinking.
- Otto, Melanie's first nephew, is born to Emilie Pick on 16th October.
- Melanie returns home from Rosenberg around Christmas 1901.

1902

- On 1st December 1902 a second sibling, Melanie's adored older brother Emmanuel, dies in Genoa of heart failure, at the age of 25. His death comes after several years of aimless and indigent travelling around the Mediterranean. He has very probably been addicted to morphine and cocaine for some time, in addition to suffering from tuberculosis.

1903

- Still in mourning for her brother, Melanie Reizes marries Arthur Klein on 31st March, the day after her 21st birthday. They set up their home in Rosenberg.
- In May Melanie finds out she is pregnant.

1904

- Klein's first child, Melitta, is born on 19th January.

1905

- Melanie, Arthur and one-year-old Melitta make a trip to the Adriatic coast, visiting a number of places including Trieste and Venice.
- Freud publishes Three Essays on the Theory of Sexuality.

1906

- In the spring, Melanie accompanies Arthur to an engineering congress in Rome.
- After four years of persevering with her friend Irma Schonfeld, Melanie finally sees the publication of a collection of Emmanuel's writing.

1907

- On 2nd March Melanie gives birth to her second child and first son, Hans, after suffering a deep depression during pregnancy.
- Late in 1907 the Kleins move to Krappitz, a small provincial town in upper Silesia (now Krapkowice, Poland), where Arthur has been appointed director of a paper mill. Libussa moves in soon afterward.

1908

- Melanie becomes increasingly anxious and depressed, clearly very unhappy in her married life in this small, friendless town. She is often away, visiting friends and family, and making trips to Budapest and Abbazia. She receives treatment – such as carbonic acid baths – for her "nerves". As a result she spends long periods of time apart from her young children, not a little encouraged by her mother Libussa in a series of strange, guilt-inducing and interfering letters.
- In this year Freud meets Hungarian pscyhoanalyst Sándor Ferenczi. The two men begin an important professional and personal relationship, recorded in more than 1,200 letters over their careers. Ferenczi is to have an enormous effect on Klein, as her analyst, supporter and friend.

1909

- In May, now severely depressed, Melanie visits a sanatorium in Chur, an alpine town in eastern Switzerland. In June she moves a little further south, to St Moritz, and is experiencing problems with her bladder. In a letter from her mother, there is a suggestion that Melanie might be afraid that she is pregnant, something that she dreads.
- In November the Kleins, with Libussa in tow, move to Svabhegy, a suburb of Budapest.
- Freud publishes his study of five-year-old 'Little Hans,' the first such analytic observation of a chlid. The analysis is carried out by the boy's father, as directed by Freud.

1910

- In the new scenery of Budapest, Melanie spends much of her time with Jolanthe Vágó, Arthur's sister, and Klara, Jolanthe's divorced sister-in-law. She is very close to these two women, especially Klara.
- Melanie spends the summer with Klara in Rügen, a resort to the north of Berlin on the Baltic Sea.
- Karl Abraham, close friend and colleague of Freud, establishes the Berlin Psychoanalytic Society. Abraham is later to analyse Klein, and to become a deeply important figure in her psychoanalytic thinking and emotional life.

1911

- In August the Kleins move to Rozsdamb, a more affluent area of Budapest.

- Again Melanie spends her summer holiday in Rügen with Klara.

1912

- Melanie writes to her mother, who is staying temporarily in Vienna, that she is feeling better, in fact "quite healthy." She refers to a "treatment" she has been having, though she does not refer to its nature. It is likely psychological, perhaps even psychoanalytical.

1913

- Around Christmas 1913, Klein finds she is again pregnant.

1914

- After another deeply depressed pregnancy, Klein gives birth to her third and last child, Erich, on 1st July. Two weeks later, on the 28th July 1914, the First World War breaks out. Both Arthur Klein and Melanie's brother-in-law Leo Pick are subsequently called up.
- Klein begins analysis with Sándor Ferenczi, a Hungarian psychoanaylst intimate with Freud and instrumental in the growth of psychoanalysis. For the first time in Klein's life she is able to talk about her emotional experiences, and to be listened to by a highly intelligent, attentive, perceptive audience of one. This encounter with Ferenczi is nothing less than a watershed in her life.
- At some point in this year Klein reads Sigmund Freud's On Dreams ('Über den Traum,' 1901). She is immediately filled with huge excitement about the insights and possibilities revealed by Freud, and becomes devoted to psychoanalysis.
- In October Ferenczi is called up to serve as a doctor to the Hungarian Hussars, though he continues to be analysed by Freud by post. He carries out some analyses himself, both in the army and on return visits to Budapest.
- In late October the Kleins take Libussa to be x-rayed, following a severe loss of weight. Cancer is ruled out by the doctor. However, she rapidly develops bronchitis, and on 6th November Melanie Klein's mother is dead.

1916

- Arthur Klein is invalided back home with a leg wound. Ferenczi also returns to Budapest, having been transferred to a neurological hospital.

1917

- Freud's famous essay, 'Mourning and Melancholia' is published. Klein will later develop her radical ideas about manic-depressive states, as well as her seminal concept of the depressive position, out of Freud's account of aggression and guilt as central to the experience of the melancholic patient.

1918

- On 28th and 29th September, Melanie Klein attends the Fifth Psychoanalytic Congress at the Hungarian Academy of Sciences in Budapest. She hears Freud read his paper, 'Lines of Advance in Psychoanalytic Therapy,' which further fuels her fascination with psychoanalysis. This is almost certainly the first time Klein hears Freud read his work in person, and will be one of the only times. For Klein this is an extraordinary moment, as she comes face to face with the brilliant and deeply revered founder of psychoanalysis.
- Toward the end of the year the Austro-Hungarian Empire dissolves as its monarchy collapses. The First World War finally ends on the 11th November 1918, after over four years of fighting and millions of lives lost.

1919

- In July Klein presents her study of her five-year-old son Erich to the Hungarian Psychoanalytic Society; it is her first study of a child. She is soon afterward awarded membership.
- Arthur Klein leaves Budapest and his family for Sweden in autumn 1919, as the anti-Semitic White Terror takes hold of Hungary. The Hungarian Psychoanalytic movement is all but destroyed by this ferocious counterrevolutionary anti-Semitism. Melanie also leaves Budapest, taking her three children to stay with Arthur's parents in Rosenberg. Besides the political turmoil, the Kleins' marriage is not working, and it is clear they are increasingly unhappy living together.

1920

- In September Klein attends the first International Congress since the war, held in The Hague. She meets Joan Riviere for the first time.
- Freud publishes Beyond the Pleasure Principle, in which he introduces the bold new idea of the 'death instinct.' This concept, controversial from its incipience, is to play a significant part in the development of Klein's theory, particularly with relation to sadism and ego-splitting in the young child.

1921

- At the beginning of 1921 Klein leaves her in-laws in Rosenburg and moves to Berlin. Other psychoanalysts have also left Hungary due to the intensifying anti-Semitic climate, including Sándor Rádo, Alexander, Schott and Balint.
- After a few weeks spent in a pension in Grunerwald, Klein moves to Cunostrasse, a drab and uninspiring area. She has Erich with her, now six years old. Melitta, aged 17, is finishing her studies in Budapest, and Hans, aged 14, is at boarding school.

1922

- Klein delivers another paper on early analysis at the 1922 International Congress. On the back of this and her paper of the previous year, she is made an Associate Member of the Berlin Society.

1923

- After being made a full member of the Berlin Psychoanalytic Society in February, Klein embarks upon her first child analysis. This marks the start of a bold new approach to analytic treatment and theory, and the start of Klein's career. This is only strengthened when Klein's paper, 'The Development of a Child,' is published by Ernest Jones in the International Journal of Psychoanalysis.
- The child Klein names 'Rita' in her notes enters analysis with her; she is only two and a half years old. In November Abraham, at that time supervising Klein's work, writes to Freud:
- "In the last few months Mrs Klein has skilfully conducted the psychoanalysis of a three-year-old with good therapeutic results. The child presented a true picture of the basic depression that I postulated in close combination with oral erotism. The case offers amazing insights into instinctual life." (A Psycho-Analytic Dialogue, The Letters of Sigmund Freud and Karl Abraham, 1906-27 [Hogarth Press, 1965], p. 339)
- Meanwhile, in her personal life, Klein and her husband Arthur attempt reconciliation, moving into a large house built by Arthur on his return from Sweden, Auf dem Grat 19, Dahlem.

1924

- Eager to learn from one of the great pioneers of psychoanalysis, Klein asks Abraham to analyse her. She manages to persuade him, despite his reservations about analysing a Berlin colleague. At the beginning of 1924 her treatment begins.
- After several months of trying to repair their marriage, relations between Melanie and Arthur fail to improve. Melanie leaves her husband for good in April, shortly after her daughter Melitta's marriage to Walter Schmideberg, a Viennese doctor and family friend of the Freuds.
- Following this final breakup of her marriage, Klein moves into a pension at Augbwigerstrasse 17, where she struggles to keep custody of Erich against Arthur's opposition.Six months into Klein's new analysis, Alix Strachey arrives from England. She is to become a very important catalyst in the development of Klein's career.
- Klein begins several important analyses of children, notably those she refers to as 'Peter,' 'Ruth,' 'Trude,' and 'Erna' in her writings. An important paper based on these cases is presented to the Berlin Society on 12th December.

1925

- A letter from Alix Strachey to her husband, outlining Klein's 1924 Berlin Society paper, stimulates great interest when read to the British Society on 7th January 1925. Klein subsequently plans to give a series of lectures in London, with the enthusiastic encouragement of Ernest Jones. The Stracheys are greatly supportive of Klein's visit, translating papers, tutoring her English, and preparing the ground in the British Society.
- During the spring Klein meets Chezkel Zvi Kloetzel, a married man and father of one, at her dance class. They begin what, at least for Klein, is a deeply affecting love affair.
- In July Klein goes to London for her lecture series, which is held at the house of Karin and Adrian Stephen (brother of Virginia Woolf) in Gordon Square. She gives two lectures per week for three weeks, to a fascinated audience. Klein meets Susan Isaacs, thus beginning an important and enduring professional and personal relationship.
- Alongside these exciting developments Klein also suffers a great loss. Abraham falls ill in May, deteriorating until he dies on Christmas Day. Klein has been in analysis with him for only a year and a half. She later describes the termination of her analysis and Abraham's death as 'very painful.'

1926

- The London Clinic for Psychoanalysis opens on 6th May, Freud’s 70th birthday.
- In September, at the invitation of Ernest Jones, Klein moves to London. She breaks off with Kloetzel (though he is to visit her several times over the next few years). Klein begins analysis of Jones’ wife and two children between 15th September and 4th October.
- On 17th November Klein gives a paper before the British Psychoanalytic Society on five-year-old ‘Peter,’ with reference to the castration complex and anal-sadistic phantasy.
- Klein's son Erich joins her on 27th December, three months after her arrival. Klein now has six patients in addition to the Jones family.

1927

- On 19th March Anna Freud addresses the Berlin Society on the subject of child analytic technique. Her presentation is a barely disguised attack on Melanie Klein’s approach to psychoanalysis. In response, Ernest Jones organises a symposium for the British Society

on the same subject. Sigmund Freud is unhappy with what he sees as an attack on his daughter and, perhaps by extension, himself.

- At the beginning of September Klein attends the Tenth International Congress, held in Innsbruck. She delivers her paper, 'Early Stages of the Oedipus Complex,' her most radical conceptual offering to date.
- Klein is elected a member of the British Psychoanalytical Society on 2nd October.

1928

- Melitta Schmideberg, Klein's eldest child and only daughter, comes to London after graduating from university in Berlin. Like her mother she is now pursuing a career in psychoanalysis, and by 1930 she is a member of the British Society. She moves in with her mother and brother Erich, while her husband Walter remains in Germany for a further four years.

1929

- Klein begins analysis of 'Dick,' a four-year-old boy, seemingly struggling with schizophrenia. His condition has since been re-described as infantile autism. This analysis and its ensuing published paper forms a key moment in Klein's development of her ideas about early psychosis and its relation to aggression and guilt.

1930

- On 5th February Klein presents a paper, 'The Importance of Symbol-Formation in the Development of the Ego' to the British Society. It forms a hugely important stage in her psychoanalytic thinking. In this seminal paper, Klein asserts that the child's capacity for symbol formation, and more broadly for the formulation of thought, are vital elements in the healthy development of the ego. This paper is truly innovative, and opened the way to a better understanding of psychotic states.

1931

- Klein takes on her first training analysand, Dr. W. Clifford M. Scott, a medical graduate from Toronto, Canada.

1932

- Klein's first major theoretical work, The Psychoanalysis of Children, is published simultaneously in English, by Hogarth Press (set up by Virginia and Leonard Woolf), and in German, by the Internationaler Psychoanalytischer Verlag. In it she lays the foundations for her later innovation of the paranoid-schizoid and depressive positions.

1933

- On 22nd May Sándor Ferenczi dies of pernicious anaemia, at the age of 59.
- Klein moves to 42 Clifton Hill, St. John's Wood. Paula Heimann, fleeing Nazi Germany, moves to London, and becomes Klein's secretary. She subsequently enters analysis with Klein.
- Melitta is elected member of the Institute of Psychoanalysis on 18th October. Previously an exponent of her mother's theoretical position, Melitta becomes increasingly antagonistic toward her, mounting regular, unsparing attacks against her ideas and method in Society meetings.
- Kloetzel moves to Palestine at the end of the year, as anti-Semitism rages ever more violently through Europe. Klein will never see him again.

1934

- At the beginning of the year Klein starts seeing Sylvia Payne once a week, for treatment of a bout of intense depression.

- Melitta begins analysis with Edward Glover, after having been previously analysed by Ella Sharpe. They become close allies against Klein in the on-going British Society infighting.
- In April, Melanie's eldest son Hans dies when a path crumbles under him as he hikes through the Tatra Mountains. He is 27. Melanie does not attend the funeral, held in Budapest, apparently too devastated to make the journey.
- Klein reads the first version of her seminal paper, 'The Psychogenesis of Manic-Depressive States' at the Lucerne Congress in August.

1935

- On 16th January Klein reads a reworked version of her 1934 Congress paper, 'A Contribution to the Psychogenesis of Manic-Depressive States,' to the British Society. The paper explains her radical, brilliant new concept, the depressive position.
- Donald Winnicott, a paediatrician and recently qualified psychoanalyst, begins analysis of Klein's youngest child Erich, at her request.
- In Germany on 15th September, the Nuremberg Laws are passed at the annual Nazi party rally. Jews are stripped of their citizenship, the right to hold influential professional positions, and the right to marry 'Aryans.'

1936

- In February Klein delivers her paper, 'Weaning,' as part of a lecture series open to the public at Caxton Hall. It will later be published as part of Love, Guilt and Reparation and Other Works 1921-1945.

1937

- On 19th March Melitta Schmideberg reads her paper, 'After the Analysis – Some Phantasies of Patients,' a searing attack on Kleinian analytic technique and theory.
- Klein goes into hospital in July, for an operation on her gall bladder. She writes 'Observations Following an Operation' afterward, detailing her emotional reactions to anaesthetic, surgery, and the return to childlike dependency.
- She spends August recuperating in Devon with Erich and his new wife, Judy.
- In September Klein takes a rare holiday in Italy.
- Klein and Joan Riviere jointly present 'Love, Guilt and Reparation,' based on a previous public lecture.
- Read Klein's 'Observations after an Operation'...

1938

- Emilie and Leo Pick, Klein's sister and brother-in-law, arrive in England as refugees from Nazi-annexed Vienna. They move into a flat around the corner from Klein.
- Sigmund and Anna Freud flee Vienna after the Nazis invade Austria in March. They arrive in London on 6th June. They are just a couple of a flood of refugee psychoanalysts fleeing Nazi Germany and Austria. The British Society is thus changed out of recognition.
- On the night of 9th-10th November, Nazi supporters and SA stormtroopers vandalise and destroy Jewish shops and synagogues across Germany and Austria, killing, beating and arresting Jews. This horrific pogrom will become known as Kristallnacht ('Night of Broken Glass').

1939

- Early in the year the Internal Object (I.O.) Group is set up, at the suggestion of Eva Rosenfeld and Susan Isaacs, as a regular opportunity for the Kleinians to discuss and formulate their ideas for presentation to their opponents.
- On 8th March the British Psychoanalytical Society celebrates its 25th birthday at the Savoy (taking 1914 rather than 1919 as the date of inception, despite the abortive nature of the first attempt). Virginia and Leonard Woolf are among the guests, and Klein meets them for the first time.
- Arthur Klein dies in Sion, Switzerland, at the age of 61.
- On 3rd September Britain declares war against Germany.
- Klein moves to Cambridge temporarily, one of many fleeing the capital for fear of air raids.
- On 23rd September, three weeks after the outbreak of the Second World War, Sigmund Freud dies at the age of 83 after years of suffering with cancer of the jaw.
- Klein re-works 'Mourning and Its Relation to Manic-Depressive States' over the winter, a paper originally given at the 1938 Paris Congress.

1940

- Klein's sister Emilie Pick dies in London in May, of lung cancer. Klein is not with her.
- At the end of June Klein leaves London for Pitlochry in Scotland, at the request of 'Dick's' parents. Meanwhile, in London, the Battle of Britain approaches, making the capital highly dangerous. She returns to London for Christmas, missing her grandson Michael and her work there.
- Edward Glover publishes An Investigation of the Technique of Psychoanalysis, a barely disguised attack on Klein and Kleinian thought.

1941

- By the new year Klein has four patients in Scotland, Dick and his brother, and two doctors. During her time in Pitlochry she keeps up a regular correspondence with Donald Winnicott, by now a close friend and ally.
- At the end of April Klein starts analysis of ten-year-old 'Richard,' whose "unusual" set of psychical difficulties prove rich food for thought. She is soon eager to write a book dedicated to this particular case.
- At the beginning of September Klein leaves Pitlochry and returns home to London.

1942

- The first of the British Society's Extraordinary Meetings takes place on 25th February, after months and years of increasing discord and infighting among its members. They are heated and often venomously personal battles between the opposing groups in the Society – the Kleinians and Viennese Freudians – and they carry on until June. In meetings Anna Freud and Edward Glover attack Klein's legitimacy as a psychoanalyst, while Melitta Schmideberg attacks her mother with a seemingly blind rage, more personal than theoretical. It looks as though the Society may not survive this deeply divisive war of ideas and personalities.
- The first of the Controversial Discussions is held on 21st October. They are highly charged debates about the conflicting psychoanalytic theories threatening to break the Society down the middle. Klein and Anna Freud are the central opponents in the struggle. During this period Kleinian theory will be criticized vehemently, and even accused of not being psychoanalytic.

1943

- Susan Isaacs' paper, 'The Nature and Function of Phantasy' (later published in Developments in Psychoanalysis) is distributed to members of the Society to be discussed on the 27th January as part of the Controversial Discussions. It is a key paper in the history of psychoanalysis, demonstrating Klein's concept of infantile phantasy as intimately related to, and sprung from, classical Freudian thought and therefore resolutely psychoanalytic. The paper forms the focus of discussion at every meeting until 19th May.

1944

- After a meeting on the 24th January, Edward Glover resigns from the British Society, declaring it no longer 'Freudian,' that is, psychoanalytic.
- On 16th February Klein takes part in the Discussions for the first time in person. She delivers the paper forming the focus of the last Controversial Discussion on 1st March, 'The Emotional Life of the Infant.'
- Hanna Segal enters analysis with Klein, around the same time as Herbert Rosenfeld. Both Segal and Rosenfeld will go on to develop and expand Kleinian theory, as they push the limits of psychoanalysis in their work with borderline-psychotic and psychotic patients.

1945

- Melitta Schmideberg leaves the UK, now separated from her husband Walter, and moves to New York. She will live there until 1961, working with adolescent delinquents.
- Klein spends August on a farm with her daughter-in-law Judy and grandchildren Michael and Diana.

1946

- On 4th December Klein gives her paper, 'Notes on Some Schizoid Mechanisms' to the British Society. This is one of the most important works of Klein's career, and a pivotal moment in psychoanalytic thought, as she details the concepts of ego-splitting and projective identification.
- After much debate within the British Society, the 'A' and 'B' groups, and what becomes known as the 'Middle Group', are at last established as an urgent means of resolving the on-going and irreconcilable differences between the Anna Freudians and Kleinians. The bitter arguments that have raged through the Society for years are now at least partly assuaged, and the Society looks like it will survive.

1947

- John Rickman, a British psychoanalyst who has been in analysis with Freud, Ferenczi and Klein, is elected president of the British Society. As a member of the 'Middle Group' - neither Anna Freudian nor Kleinian - Rickman's appointment is a deliberate effort to preserve neutral government of the Society.

1948

- Susan Isaacs dies of cancer on 12th October, at the age of 63.

1949

- At the sixteenth Psychoanalytic Congress in Zurich, Klein sees her daughter Melitta for the first time in four years. They do not speak.

1950

- Some rare, silent cine footage shows Melanie Klein walking in the garden of her home in Clifton Hill at about this time. The identity of the filmmaker, and of the gentleman who appears with Klein, are unknown.

1951

- In preparation for the celebration of Klein's 70th year, her colleagues and friends publish Developments in Psychoanalysis, including essays by Heimann, Isaacs, Riviere, Klein, and others.
- Klein's former lover Chezkel Zvi Kloetzel dies on 27th October.

1952

- Ernest Jones organises a dinner at Kettner's (29 Romilly St, Soho) to celebrate Klein's 70th birthday.
- In photograph, clockwise from left: [sitting] Marion Milner, Sylvia Payne, Eric Klein, Roger Money-Kyrle, Clifford Scott, Paula Heimann, James Strachey, Gwen Evans, [unknown], Michael Balint, Judy Klein (wife of Eric Klein), [standing] Melanie Klein, Enest Jones, Herbert Rosenfeld, Joan Riviere, Donald Winnicott

1953

- After a period of illness and dizzy spells (and a brief spell in hospital), thought to be brought about by excessive tiredness and overwork, Klein sells her house at Clifton Hill and moves to a smaller flat at 20 Bracknell Gardens, West Hampstead.
- Klein begins work on her autobiography (never published). Professor Janet Sayers has transcribed and annotated the fragments contained in the Melanie Klein archive at the Wellcome Trust. Published in Psychoanalysis and History, 15(2), 2013: 127-663.

1954

- Walter Schmideberg, Klein's estranged son-in-law, dies of an ulcerous illness in Switzerland, by now long separated from his wife Melitta.

1955

- On 1st February Klein establishes the Melanie Klein Trust, something she has thought of doing for several years. She invites Wilfred Bion, Paula Heimann, Betty Joseph, Roger Money-Kyrle, and Hanna Segal to be trustees, and puts in £600 to get it going.
- New Directions in Psychoanalysis is published.
- Klein attends the Geneva Congress, held on 24th-25th July. On the first day, Klein delivers a paper, 'A Study of Envy and Gratitude.' It is among the most controversial of all Klein's papers, and elicits a heatedly critical reaction. Paula Heimann, by now no longer on good terms with Klein, is among those critical of the paper's assertions.
- On 24th November Klein writes to Heimann, asking her to resign as trustee of the newly established Melanie Klein Trust. Spelling the end of their long and close friendship, Heimann soon after also leaves the Kleinian group.

1956

- Klein, with the help of previous analysand Elliott Jaques, starts to sort through and order her notes on Richard. These notes will become Narrative of a Child Analysis, her only full-length account of a single analysis.
- On 6th May the Society marks Freud's centenary year.

1957

- The highly controversial Envy and Gratitude is published in June, expanded from Klein's 1955 Geneva Congress paper with the help of Elliot Jacques.
- On her 75th birthday, Klein is given a Victorian garnet and gold set of jewellery by the British Society.

1958

- Ernest Jones dies on the 11th February, at the age of 79.

- Listen to a recording of Melanie Klein's voice made at around this time.

1959

- After previously being taken up and then unfinished by French psychoanalyst and philosopher Jacques Lacan, Klein's Psycho-Analysis of Children is finally published in a French translation by Françoise and Jean-Baptiste Boulanger.
- Klein reads her paper, 'Our Adult World and Its Roots in Infancy' to an audience of sociologists in London.
- Klein gives her paper, 'On the Sense of Loneliness' at the Copenhagen Congress in July. In it she explores the yearning for an unattainable return to the baby's first experience of an entirely devoted mother figure. The paper will later be published as part of Envy and Gratitude and Other Works 1946-1963.

1960

- In the spring Klein is diagnosed with anaemia, and is increasingly exhausted and physically weak.
- During the summer Klein goes to Switzerland, to Villars-sur-Ollon, determined to regain her health. Her son Eric joins her, but by this time she has grown dangerously ill. She returns to England and is immediately taken to hospital. Colon cancer is diagnosed and Klein has an operation at the start of September. The operation seems at first to have been successful, but complications arise after she falls out of bed and breaks a hip. Melanie Klein dies on 22nd September.
- She is cremated at Golders Green Crematorium, her funeral attended by many friends and colleagues. Melitta is not there.

QUOTES

"One of the many interesting and surprising experiences of the beginner in child analysis is to find in even very young children a capacity for insight which is often far greater than that of adults. "

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Perceived Social Support of HIV/AIDS Orphans

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ABSTRACT

The present study examined the group and gender deference in Perceived social support (PSS) on a sample of HIV/AIDS orphans and non- HIV/AIDS orphans. The sample of the study consisted of 236 orphans (116 HIV/AIDS orphans and 120 non- HIV/AIDS orphans) the mean age of HIV/AIDS orphans, 11.66 years and mean age of non-HIV/AIDS orphans, 11.78 years living in the north Indian orphanages. The tools employed for present study is PSS scale for children consisting of 30 items and comprising of three subscales assessing the source of the emotional support (i.e., family, friends, or teacher). Result related to MANOVA indicates that significant group difference ($F=2.66$, $p<0.05$) and significant gender difference ($F=2.66$, $p<0.05$) was found in HIV/AIDS orphans and non-HIV/AIDS orphans on perceived social support. The present research explored low PSS of HIV/AIDS orphans living in Indian orphanages. PSS plays a protective role in dealing with psychosocial outcomes of HIV/AIDS orphans. Strong perception of support from cares, siblings, school teachers, school principal, friends, and others may reduce the deleterious effects of exposure to illness and psychological problems.

Keywords: *HIV/AIDS Orphans, Non- HIV/AIDS orphans and Perceived social support*

HIV/AIDS is one of the most destructive diseases humankind has ever faced. Human Immunodeficiency Virus (HIV), is the virus that causes AIDS. HIV destroys certain blood cells that are crucial to the normal functioning of the immune system, which defends the body against illness. Acquired Immuno Deficiency Syndrome (AIDS) occurs when the immune system is weakened by HIV virus to the point where a person is susceptible to numerous opportunistic infections or diseases.

Today, India is the home to the largest number of AIDS orphans in the world (UNAIDS, 2013). It is expected to become the next epicenter of AIDS orphan crises. In India, over 31 million children are orphaned due to various causes including HIV (UNICEF, 2010). In India about 170,000 adult deaths per year (of the total 2.3 million adults living with HIV) can be traced to HIV (NACO, 2010-11). This makes the problem of AIDS orphans significant in our country.

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HIV/AIDS Orphan is a relatively new concept. A child under 18 years who has lost either or both parents because of AIDS is HIV/AIDS orphans and is further categorized as a maternal, paternal and double orphan (UNAIDS, UNICEF & USAIDS (2004). Chitiyo, Changara, and Chitiyo (2008) defined an AIDS orphan as a child who has lost one or both parents to HIV/AIDS.

Social support has been defined as an exchange of resources between two individuals perceived by the provider or recipient to be intended to enhance the wellbeing of the recipient (Shumaker and Brownell, 1984). Perceived social support (PSS) is a term encompassing a variety of characteristics of an individual's social world and relationship between the individual and the social environment (Haber, Cohen, Lucas, and Baltes, 2007). It is defined as the perception or experience that social support is available if someone liked to reach the support of another person (Sarason et al., 1983) and as cognitive variable influencing interactions with other people (Lakey and Cassady, 1990). It can be defined as a perceived financial, physical, and emotional help from family, friends, and the community at large (Dirkzwager, Bramsen, and van der Ploeg, 2003). Although definitions vary, PSS can be defined as those social interactions that provides individuals with actual assistance or embeds them into a web of social relations perceived to be caring and readily available in times of need (Hobfoll, 1989). PSS has been shown to be consistently linked to better health and psychological well-being outcome (Williams, 1995; Sacco, and Yanover, 2006; Haber, Cohen, Lucas, and Baltes, 2007), psychological adjustment, improved efficacy, self-esteem and social competence.

Social support systems have been shown to be effective in addressing mental health and behavioral problems among HIV/AIDS orphans, particularly depression, conduct problems and problematic behaviors (Lee, Deteis, Rotheram-Borus, and Duan, 2007). While there is currently a growing body of global literature on the well-being of HIV/AIDS orphans (Cluver and Gardner, 2007; Lee, Detels, Rotheram-Borus, and Duan, 2007; Li et al., 2009; Zhao et al., 2007), limited research and data are available regarding the PSS of HIV/AIDS orphans (Verma & Lata, 2015). Hong et al., (2010), examined the relationship between PSS and psychosocial distress of HIV/AIDS orphans. A strong association was found between PSS and psychosocial distress, which was consistent with global literature on the 'buffer' function of PSS. All aspects of social support, including support from family, friends, teachers and significant others are imperative for children affected by HIV/AIDS. Data on protective role of PSS on trauma in HIV/AIDS orphans is limited. Cluver, Fincham, and Seedat, 2009, examined the relationship between PSS and Post traumatic Stress Disorder (PTSD). Findings from this study revealed that substantial amount of social support from cares, school staff, and friends may reduce the adverse effects of exposure to trauma, and should be included as the main theme of intervention designed to improve psychological outcomes of HIV/AIDS orphans. Furthermore, the study suggested that PSS may act as a protective factor against the onset of clinical-threshold PTSD (Verma & Lata, 2015).

HIV/AIDS orphans have poor mental health, and their psychosocial wellbeing vary by their orphan hood status (Fang et al., 2009; Zhao et al., 2007). They have lower PSS as compared to other children (Ferreira, Keikelame, and Mosaval, 2001; Manuel, 2002) due to the loss of their mother, father or both. They lose close human relationships as a result of changing caregivers, repeated moves and

bereavement (Cluver and Gardner, 2007). Under these circumstances, social support is worth utilizing as a low-cost critical resource for the care of HIV/AIDS orphans (Thurman et al., 2006) as it can reduce the incidence of mental illness (Callaghan and Morrissey, 1993).

RATIONALE OF THE PRESENT STUDY

HIV/AIDS is an emerging area of research. Research on Indian HIV/AIDS orphans is limited. Present research is being conducted for understanding the state of HIV/AIDS orphans in India. In literature survey numerous studies were found related to HIV/AIDS children but research on HIV/AIDS orphans is scarce in India. Due to lack of support and care, HIV/AIDS orphans are at higher risk of bad health and nutritional problems. They are forced to leave school, engage in labour or prostitution, suffer from depression and anger, and engage in risky behaviours etc. Lack of social support owing to illness or death of family members lead to distorted cognitions of themselves and others which of itself lead to reduced perceptions of social support**.** There is paucity of studies on PSS among HIV/AIDS orphans.

On the basis of review of literature the following objectives were formulated for the study:

1. To assess the group differences in PSS in HIV/AIDS orphans and non-HIV/AIDS orphans.
2. To assess the gender differences in PSS in HIV/AIDS orphans and non-HIV/AIDS orphans.

On the basis of review of literature the following hypotheses were formulated for the study:

H_1. PSS would be lower in HIV/AIDS orphans than non HIV/AIDS orphans.

H_2. There would be significant gender differences in PSS in HIV/AIDS orphans than non-HIV/AIDS orphans.

Research Design of the study

The study is a ex-post facto research design. This is because the children were already orphaned. In the study 2x2 factorial design is applied. Two groups of orphans (HIV/AIDS orphans and non-HIV/AIDS orphans) and gender (boys and girls) as two factors were used.

Sample

With help of the snowball sampling 236 orphans (131 boys and 105 girls) were selected for the study. 116 were HIV/AIDS orphans (71 boys and 45 girls) and 120 were non-HIV/AIDS orphans (60 boys and 60 girls). Mean age of HIV/AIDS orphans was 11.98 years (boys mean age was 10.17 years and girls mean age was 12.15 years), mean age of non-HIV/AIDS orphans was 12.65 years (boys mean age was 13.15 years and girls mean age was 12.31 years). Data were collected from different orphanages of north India with the approval from the authorities.

Measures

Demographic sheet:

Perceived Social Support Scale for Children: It is self-developed scale in hindi. It consists of 30 items and comprises of three subscales assessing the sources of the PSS (i.e., family, friends, and

teacher) using a 5-point response option (ranging from 1 = 'strongly disagree' to 5 = 'strongly agree'). The alpha-coefficient is .94.

Pilot Study

The self-constructed PSS scale in Hindi of 54 items was used for pilot study. Pilot study was conducted on the research sample of 32 HIV/AIDS orphans, age ranging from 10 to 17 years. The purpose of the pilot study was to examine the appropriateness, understanding and finalizing the constructed scale. After conducting the pilot study the reliability of all items was calculated with the help of SPSS. Range of item total correlation was found to be .797 to .120. 10 items were selected from each domain namely- friend, teacher and family thus finally total 30 items were retained in the final questionnaire.

Data Collection

Being assured of the appropriateness of the scale, data collection for the main study was started. Before starting the data collection, consent was taken from the caregivers of the orphans. All information related to study was given to participant verbally and in written form. Further process was done only after their consent had been received for participation in the study. A rapport was established with the participants before the test administration, so that they may feel free to give their response. They were encouraged to answer all items. No individual names or other identifiers were used in the data sheets. All subjects completed the demographic information and PSS scale for children.

Statistical Analysis

The collected data were coded and entered into the Statistical Program for the Social Sciences (SPSS version 17.0) for analysis. Descriptive statistics was applied for each of the variables. Coded scores were analysed in term of ANOVA and MANOVA for computing the differences in group of orphans and gender. Tukey's test was used for multiple comparisons of means.

RESULTS

Group Differences in PSS

Results related to group differences between HIV/AIDS orphans and non-HIV/AIDS orphans on PSS has been presented in the Table 1 and Figure 1.

Table 1 Group Differences inPSS

Dimensions of PSS	Group of Orphans				F
	HIV/AIDS Orphans (n=116)		Non-HIV/AIDS Orphans (n=120)		
	Mean	*SD*	Mean	*SD*	
Friend PSS	33.28	*7.20*	35.34	*12.54*	2.095
Teacher PSS	31.88	*8.62*	35.89	*12.71*	7.557**
Family PSS	34.92	*8.21*	37.90	*12.64*	4.356*

*p<0.05, **p< 0.01

Figure 1 Bar Diagram of Group Differences in Perceived Social Support

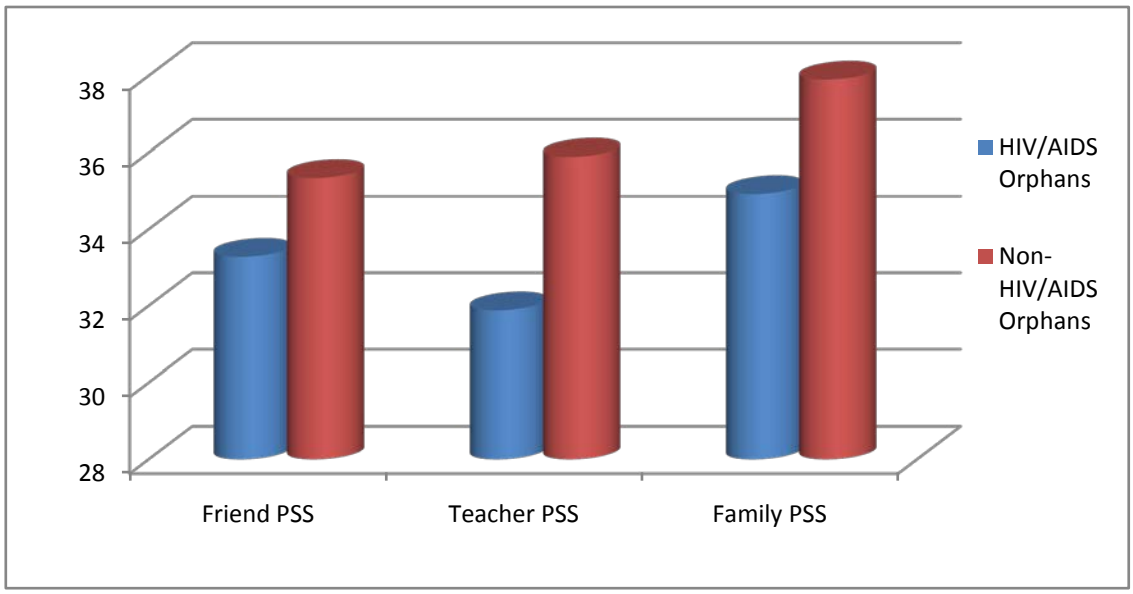


Table1 and Figure1 shows that mean and SD values of HIV/AIDS orphans and non-HIV/AIDS orphans on friend PSS was 33.28 (7.20) and 35.34 (12.54), on teacher PSS was 31.88 (8.62) and 35.89 (12.71) and on family PSS was 34.92 (8.21) and 37.90 (12.64) respectively.

In MANOVA the four most commonly used multivariate tests (Pillai's Criterion, Wilks's Lambda, Hotelling's Trace and Roy's Largest Root) indicates that significant difference was found between HIV/AIDS orphans and non-HIV/AIDS orphans on PSS ($F=2.66$, $p<0.05$). Univariate statistical test (ANOVA) for each dimension of PSS shows significant difference between HIV/AIDS orphans and non-HIV/AIDS orphans on teacher and family PSS ($F=7.56$, $p<0.01$ and $F=4.36$, $p<0.05$). Insignificant difference ($F=2.10$, $p>0.05$) was found between the two group of orphans - HIV/AIDS orphans and non-HIV/AIDS orphans on friend perceived social support. This is confirmed by the means of group differences reported in Table 1 and Figure.1.

Gender Differences in PSS

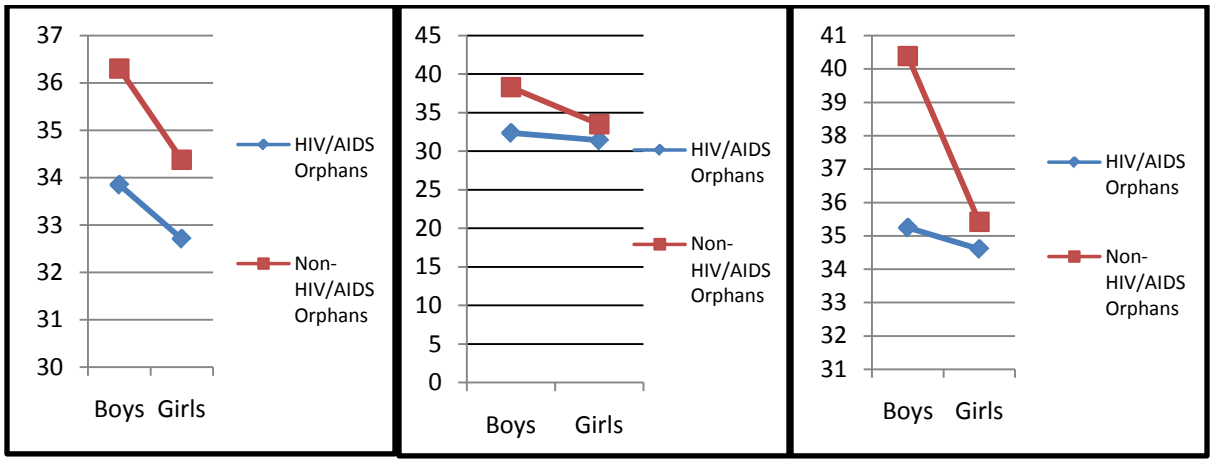
Result related to gender difference in HIV/AIDS orphan and non-HIV/AIDS orphan on PSS has been presented in Table 2 and Figure 2.

Table 2 Gender Differences in PSS

Dimensions of PSS	Group of Orphans				F
	HIV/AIDS orphans		Non-HIV/AIDS orphans		
	Boys (n=71)	Girls (n=45)	Boys (n=60)	Girls (n=60)	
	Mean *(SD)*	Mean *(SD)*	Mean *(SD)*	Mean *(SD)*	
Friend PSS	33.85[a] *(6.66)*	32.71[a] *(8.02)*	36.30[a] *(9.78)*	34.38[a] *(14.83)*	1.16
Teacher PSS	32.37[a] *(7.92)*	31.40[a] *(9.68)*	38.28[b] *(10.06)*	33.50[a] *(14.59)*	4.51*
Family PSS	35.24[a] *(8.29)*	34.60[a] *(8.17)*	40.38[b] *(9.18)*	35.42[a] *(15.02)*	3.76*

*p<0.05, **p< 0.01

Figure 2 Graphical Presentations of Gender Differences



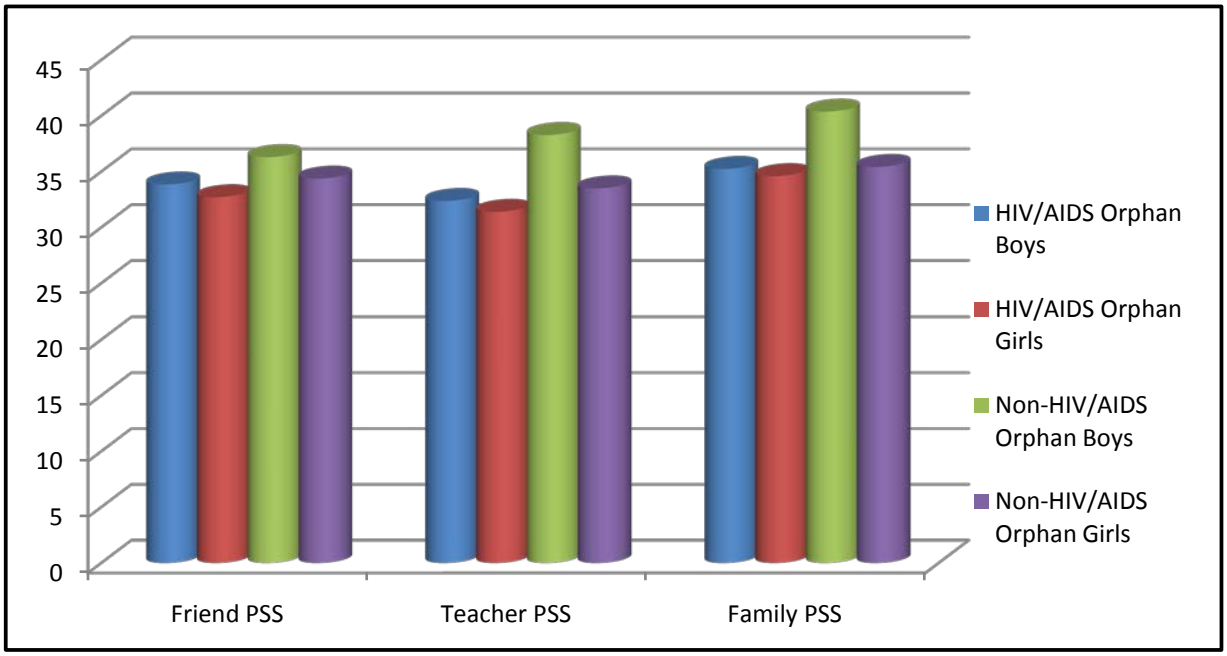
Friend PSS **Teacher PSS** **Family PSS**

Table 2 and Figure 2 shows that the mean and SD value of HIV/AIDS orphan boys and girls on friend PSS were 33.85 (6.66) and 32.71 (8.02) and non-HIV/AIDS orphan boys and girls were 36.30(9.78) and 34.38 (14.83). The mean and SD value of HIV/AIDS orphan boys and girls on teacher PSS were 32.37 (7.92) and 31.40 (9.68) and non-HIV/AIDS orphan boys and girls were 38.28 (10.06) and 33.50 (14.59). The mean and SD value of HIV/AIDS orphan boys and girls on family PSS were 35.24 (8.29) and 34.60 (8.17) and non-HIV/AIDS orphan boys and girls were 40.38 (9.18) and 35.42 (15.02).

In MANOVA the four most commonly used multivariate tests (Pillai's Criterion, Wilks's Lambda, Hotelling's Trace and Roy's Largest Root) were employed. Each of the four measures indicates that significant gender difference was found between HIV/AIDS orphans and non-HIV/AIDS orphans on PSS ($F=2.76$, $p<0.05$). Univariate statistical test (ANOVA) for each dimension of PSS shows significant gender difference between HIV/AIDS orphans and non-HIV/AIDS orphans on teacher and

family PSS (F=4.51, p<0.05 and F=3.76, p<0.05). Insignificant gender difference was found between HIV/AIDS orphans and non-HIV/AIDS orphans on friend PSS (F=1.16, p>0.05). This is confirmed by the means of group differences by gender reported in Table 2 and Figure 2.

Figure 3 Bar Diagram of Tukey's-HSD Test for Gender Difference on PSS between HIV/AIDS Orphans and Non-HIV/AIDS Orphans



Results related to post hoc comparison of means with the help of Tukey's- HSD test are presented in Table 2. Figure 3 shows that insignificant mean difference was found in friend PSS between all the possible groups. Significant mean difference was found in teacher PSS between HIV/AIDS orphan boys and non-HIV/AIDS orphan boys (-5.91, p<0.05), HIV/AIDS orphan girls and non-HIV/AIDS orphan boys (-6.88, p<0.01), and non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls (-4.78, p>0.05). Significant mean difference was found in family PSS between HIV/AIDS orphan boys and non-HIV/AIDS orphan boys (-5.14, p<0.05), HIV/AIDS orphan girls and non-HIV/AIDS orphan boys (-5.78, p<0.05), and non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls (-4.97, p>0.05).

DISCUSSION

PSS is the perceived financial, physical and emotional help from family, friends, teachers and the community at large. It is a recipient's subjective judgment that providers will offer (or have offered) effective help during times of need. PSS scale comprises of three subscales assessing the source of the financial, physical and emotional support from friends, teachers and family.

Group difference in PSS

Result related to MANOVA indicates that significant group difference was found in HIV/AIDS orphans and non-HIV/AIDS orphans on perceived social support. Thus, the Hypothesis 1 is accepted on the basis of this observation. PSS of HIV/AIDS orphans was lower than non-HIV/AIDS orphans. This finding has been supported by Nyamukapa, et al., (2010) and Xu, et al., (2009). Lower PSS of HIV/AIDS orphans may be due to the prevalence of HIV related stigma, bullying, discrimination, HIV infection, inadequate care, physical abuse, school dropout and failure, food insecurity, changes in the interpersonal relationship, less care and support from the friends, teachers, rehabilitation centers and caregivers. The HIV/AIDS orphans are unable to talk about their personal problems with their friends and regularly attend school due to poor health. They had limited interactions with their teachers and friends. They perceived that their family, the orphanage staff supported them in their medical health care but they did not motivate and helped them for academics and other life engagements.

Friend PSS

Result related to ANOVA indicates insignificant group difference in HIV/AIDS orphans and non-HIV/AIDS orphans on friend perceived social support. HIV/AIDS orphans perceived lower friend PSS than non-HIV/AIDS orphans. HIV/AIDS orphans realized that their friends were playing, talking and studying with them but they could not talk about their personal problems with them due to shame and guilt. They also do not feel comfortable sharing their problems with their friend. They do not find them capable enough to solve their problems. Thus they perceived low social support from friends. Study reveals that most of the HIV/AIDS orphans strongly disagreed with the items of PSS scale for children like- I can talk about my personal problems with my friend (item no. 1) and My friends are always with me at the time of need (item no. 5).

Teacher PSS

Result related to ANOVA indicates significant group difference in HIV/AIDS orphans and non-HIV/AIDS orphans on teacher perceived social support. HIV/AIDS orphans perceived lower teacher PSS than non-HIV/AIDS orphans. HIV/AIDS orphans do not go to school regularly due to poor health. They perceived low affection, attachment and interaction from their teachers. Most of the HIV/AIDS orphans strongly disagreed with the items like- My teacher is always with me at the time of need (item no. 13) and My teacher cares of my feelings (item no. 15).

Family PSS

Result related to ANOVA indicates significant group difference in HIV/AIDS orphans and non-HIV/AIDS orphans on family perceived social support. HIV/AIDS orphans perceived lower family PSS than non-HIV/AIDS orphans. HIV/AIDS orphans perceived that their family took great care of their health but they did not encourage them for better studies and other aspects of life. Most of the HIV/AIDS orphans strongly disagreed with the items like- My family helps me in studies (item no. 23) and My family motivates me to achieve good grades in class (item no. 26).

Gender difference in PSS

Result related to MANOVA indicates that significant gender difference was found in HIV/AIDS orphans and non-HIV/AIDS orphans on perceived social support. Thus, the Hypothesis 2 is accepted on the basis of this observation.

Friend PSS

Result related to ANOVA indicates insignificant gender difference in HIV/AIDS orphans and non-HIV/AIDS orphans on friend perceived social support. Further Tukey's-(HSD) Test result also indicates insignificant gender difference between HIV/AIDS orphan boys and HIV/AIDS orphan girls on friend perceived social support. HIV/AIDS orphan boys and girls perceived lower friend perceived social support. HIV/AIDS orphan boys and girls due to HIV infection and opportunistic infections witnessed insufficient supports and care from their friends. Most of the HIV/AIDS orphans strongly disagreed with the items like- I can talk about my personal problems with my friend (item no. 1) and My friend wants to be with me (item no. 8).

Insignificant gender difference was also found between non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls on friend perceived social support. Non-HIV/AIDS orphan boys and girls both are free from infection or any other medical problem. They experience PSS from their friends during times of need. Mean value depicts that friend PSS of non-HIV/AIDS orphan boys were slightly more than non-HIV/AIDS orphan girls. The reasons attributed to it can be that they could easily share their problems with their friends. They feel that their friends love them and are readily available to comfort them at the time of need. Most of the non-HIV/AIDS orphan boys strongly agreed with the items like- My friend loves me (item no. 7) and When I'm upset, my friend comforts me (item no. 2).

Teacher PSS

Result related to ANOVA indicates significant gender difference in HIV/AIDS orphans and non-HIV/AIDS orphans on teacher perceived social support. Further, Tukey's-(HSD) Test result also indicates insignificant gender difference between HIV/AIDS orphan boys and HIV/AIDS orphan girl son teacher perceived social support. HIV/AIDS orphans due to several health problems visualize insufficient supports and care from their teachers. They observe that their teachers are not compassionate and stigmatized due to HIV infection. Most of the HIV/AIDS orphan boys and girls strongly disagreed with the items like- My teacher worries about my future (item no. 17) and My teacher is always with me at the time of need (item no. 26).

Significant gender difference was found between non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls on teacher perceived social support. Thus, ANOVA result was significant due to significant gender difference between non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls on teacher perceived social support. Non-HIV/AIDS orphan boys and girls are healthy and experience PSS from their teachers during times of need. Their teachers are passionate and help them because of their circumstances and destiny. Mean value depicts that teacher PSS of non-HIV/AIDS orphan boys were higher than non-HIV/AIDS orphan girls. Most of the non-HIV/AIDS orphan boys agreed with the

items like-My teacher gives good suggestions and advice about my problems (item no. 20) and My teacher helps me in studies (item no. 12).

Family PSS

Result related to ANOVA indicates significant gender difference in HIV/AIDS orphans and non-HIV/AIDS orphans on family perceived social support. Further, Tukey's-(HSD) Test also indicates insignificant gender difference between HIV/AIDS orphan boys and HIV/AIDS orphan girls on family perceived social support. HIV/AIDS orphans experience insufficient support, help and care from their family i.e. the orphanage. They also miss the family environment. Most of the HIV/AIDS orphan boys and girls strongly disagreed with the items like- My family makes me laugh when I am crying (item no. 25) and My family always motivates me towards better living (item no. 28).

Significant gender difference was found between non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls on family perceived social support. Thus, ANOVA result was significant due to significant gender difference between non-HIV/AIDS orphan boys and non-HIV/AIDS orphan girls on family perceived social support. Non-HIV/AIDS orphan boys and girls experience equal PSS from their family during times of need. Mean value depicts that family PSS of non-HIV/AIDS orphan boys was higher than non-HIV/AIDS orphan girls. The reasons attributed to it can be that being orphans, they live normal healthy life. Their family motivates them toward better living and help in their studies for achieving better career as compared to non-HIV/AIDS orphan girls. Most of the non-HIV/AIDS orphan boys strongly agreed with the items like- My family always motivates me towards better living (item no. 28) and My family helps me in studies (item no. 23).

CONCLUSION

Result related to MANOVA indicates that significant group difference was found in HIV/AIDS orphans and non-HIV/AIDS orphans on perceived social support. PSS was lower in HIV/AIDS orphans as compared to non-HIV/AIDS orphans. Result related to MANOVA indicates that significant gender difference was found in HIV/AIDS orphans and non-HIV/AIDS orphans on perceived social support. Substantial amount of social support from family, care takers, friends, school staff and mental health services should be provided to alleviate stressful life events and improve psychosocial wellbeing. Peer-group intervention would be effective in enhancing PSS of HIV/AIDS orphans. Appropriate interventions should be undertaken to promote school performance of children orphaned by AIDS and to mitigate the interactive stressors of AIDS-orphan hood and trauma exposure on childhood PTSD. Community interventions should be promoted to improve the situations of these children e. g. educational assistance, home-based care, legal protection, and psychosocial support. Counseling services should be recommended as a specific psychological intervention.

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

The limitations observed during the process of completion of present study are being presented and may be applied for improving future research on HIV/AIDS orphans. The present study was conducted on the small sample. Future research may consider a wider range sample and longer study period. The

present study examined differences between double HIV/AIDS orphans and non-HIV/AIDS orphans but comparison between double orphans, paternal orphans and maternal orphans were not included in the present study. Future research may focus on including comparison between all types of HIV/AIDS orphans. The present study focuses on gender difference but in HIV/AIDS orphans group, numbers of girls are less than HIV/AIDS orphans boys. This is because there are few HIV/AIDS orphan girls enrolled in North Indian orphanages. Future research may include equal number of HIV/AIDS orphans boys and girls for better interpretation of the results. The present study explored the current status of PSS but did not plan any intervention programs for their betterment. Future research may include interventions for their overall development and betterment.

IMPLICATIONS FOR FUTURE RESEARCH

The present research explored low PSS of HIV/AIDS orphans living in Indian orphanages. PSS plays a protective role in dealing with psychosocial outcomes of HIV/AIDS orphans. Strong perception of support from cares, siblings, school teachers, school principal, friends, and others may reduce the deleterious effects of exposure to illness and psychological problems. The study emphasizes the provision of peer group intervention programs in the orphanage settings for developing the feeling of togetherness and brotherhood and thus enhancing PSS of HIV/AIDS orphans.

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Impact of Religion, Caste, Income and Type of Family on the Mental Health of Teacher Trainees

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ABSTRACT

The present study aimed at finding out The Impact of Religion, Caste, Income and Type of Family on The Mental Health of Teacher Trainees. The samples of the present study comprised 200 Teacher trainees of B.Ed class from different colleges of Ambala district have been taken. Out of 200 Teacher Trainees 100 Teacher Trainees are male and 100 Teacher Trainees are female. Mental Health Analysis Questionnaire developed by Manju Rani (1989) was used.

Keywords: *Religion, Caste, Income, Type of family and Mental Health.*

There is a very intimate relation between religion and education. An effective educational system includes only those values in human beings which are valued and recognized by all the philosophies of the world. Religion and education are natural allies. Both recognize have to do with the spiritual as against an exclusively material attention to the environment, but from slavery to it, to enlarge his horizon and quicken his aspiration.

The family is the oldest, basic and fundamental unit of human society. It consists of the husband, wife, and children together with all the young and old dependents. They are related to one another in one way or the other. A child gets his first lesson in the family. The impression gained and the family environment indelible and remain for the whole life. A number of educationists have spoken very highly about the role of family in the education of a child.

REVIEWS OF RELATED LITERATURE

O'Rourke (1986) and Amero et.al (1987) reported positive relation between income and mental health. **Kalpat (1992**) studies deprivation and academic anxiety of students belonging to Hindu higher caste, backward caste and Scheduled castes. It is found that as deprivation level increases, academic anxiety also increases. Scheduled caste high deprived students possess more academic anxiety in comparison to backward high deprived and higher caste high deprived respectively**. Dhooper and tran (1998) Dhoopper and Tran (1998)** stated that Asian refugees

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in the United states have health and mental health needs that are different from those of mainstream Americans and even of recent immigrants. **Indu Kaura (1998)** stated that the break up of the joint family system has contributed largely to 'Problem- Parents'. Once of the joint family system acted as a great buffer, but now with the proliferation of the nuclear family set-up, both parents and children find the going a lot more tough. **Mythili, Bharati and Nagarathna(2004)** investigated the adjustment problems of adolescents students and revealed that boys have more adjustment problems when compared to girls and students from private colleges experienced more problems than Government colleges.

Arati, Ratna Prabha (2004) conducted a study with an objective of studying the mental health and emotional competence of adolescents .the result revealed the mental health had significant influence on emotional competence of adolescents.

OBJECTIVES

1. To study the Mental Health of Hindu and non- Hindu teacher trainees.
2. To study the Mental Health of Forward and Backward Caste teacher trainees.
3. To study the Mental Health of teacher trainees belonging to High and Low family Income groups.
4. To study the Mental Health of teacher trainees from Nuclear and Joint families.

Hypotheses

1. There is no significant effect of Religion on Mental Health of Teacher trainees.
2. There is no significant effect of Caste on Mental Health of Teacher trainees.
3. There is no significant effect of Family Income on Mental Health of Teacher trainees.
4. There is no significant effect of Nuclear and Joint Families on Mental Health of Teacher trainees.

Sample

The sample of the present study comprised of 200 teacher trainees drawn randomly from different Education Colleges of Ambala District. Out of 200 teacher trainees 100 male and 100 female teacher trainees were taken.

Tool

Mental Health Analysis Questionnaire developed by Manju Rani (1989) was used to assess the Mental Health Status of the subjects.

RESULT

Table -1, Mean, S.D and 't' ratio for the Mental Health Score of Hindu and Non-Hindu Teacher Trainees

Religion	N	Mean	SD	't' ratio
Hindu	98	60.5	6.24	9.662*
Non- Hindu	102	52.4	5.45	

Table -2, Mean, S.D and ' t' ratio for the Mental Health Score of Forward and Backward Caste Teacher Trainees

Castes	N	Mean	SD	't' ratio
Forward Caste	96	59.96	5.25	5.242*
Backward Caste	104	55.19	7.5	

Table -3, Mean, S.D and 't' ratio for the Mental Health Score of Teacher Trainees from High and Low Family Income Groups

Income	N	Mean	SD	't' ratio
High Income	60	60	5.95	15.061*
Low Income	140	45	7.5	

Table -4, Mean, S.D and 't' ratio of Mental Health Score of Teacher Trainees from Nuclear and Joint Families.

Religion	N	Mean	SD	't' ratio
Hindu	90	59	7.5	1.349
Non- Hindu	110	57.5	8.2	(NS)

DISCUSSION

Entries made in **Table 1** 't'-ratio for the mean scores of mental health is which is significant at 0.01 level indicate that there is significant difference between Hindu and Non-Hindu Teacher Trainees with regard to their mental health. It is clearly indicates the mental health of Hindu

Teacher Trainees (Mean = 60.5) are better than the mental health of Non-Hindu Teacher Trainees (mean = 52.4)

Entries made in **Table 2** 't'-ratio for the mean scores of mental health is which is significant at 0.01 level indicate that there is significant difference between the forward caste and backward caste Teacher Trainees with regard to their mental health. It is clearly indicates the mental health of forward caste Teacher Trainees (Mean = 59.96) are better than the mental health of backward caste Teacher Trainees (mean = 55.19)

Entries made in **Table 3**'t'-ratio for the mean scores of mental health is which is significant at 0.01 level indicate that there is significant difference between High Income group and Low Income Group Teacher Trainees with regard to their mental health. It is clearly indicates the mental health of High Income group Teacher Trainees (Mean = 60) are better than the mental health of Low Income group Teacher Trainees (mean = 45)

Entries made in **Table 4** 't'-ratio for the mean scores of mental health is which is not significant at both the levels. So there is no significant difference on mental health between Teacher trainees from Nuclear and Joint Families.

CONCLUSION

- Teacher Trainees from Hindu Families are better in their mental Health than the Teacher Trainees from Non-Hindu Families.
- Teacher Trainees belongs to Forward Caste are better in their mental Health than the Teacher Trainees of Backward Caste.
- Teacher Trainees from High Income Group are better in their mental Health than the Teacher Trainees from Low Income Group.
- There is no significant difference on mental health between Teacher trainees from Nuclear and Joint Families.

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Story Telling as a Method of Health Education

Prabhakararao Sampathirao[1]*

ABSTRACT

Storytelling is one approach of many that can make it more likely that someone will take action. It can happen face-to-face, through books, videos, audio, comics and any of the other myriad ways people communicate with each other. When you combine different media, and tell stories from alternate points of view, it gets even more interesting. Storytelling is a powerful tool to bring about health and social change, when it is combined with proven behavior change models-social marketing and entertainment education principles, it has the potential of radical transformation of social norms with the help of transmedia approach i.e., using different platforms for telling different parts of a story rather than the same story told over and over again via various media. Social media has offered lot of scope and opportunity to incorporate story telling in public health education.

Keywords: *Story Telling, Health, Education*

Storytelling has been around since cavemen sat around the fire telling each other about the mammoth that got away. Story telling is imbibed in our culture and inherited from our ancient forefathers to learn and propagate knowledge. Story telling has its roots in hymns, poetry, songs and drama and hence entertainment to instill lasting memory. *Bhagwadgita*, the repository of Hindu way of life has its origin in the word '*gitam*' which means song in Sanskrit. These songs have different forms according to their comprehension and understanding by different people with different intellectual capacities. For advanced scholars (*vidvans*) they are hymns (*slokas*), for a person with moderate expertise they are poetry with proper rhyme and rhythm and rules of grammar, for ordinary people they are *lokgeet* (local songs).

In the ancient times, when there was no record of ideas on paper, important truths in daily walks of life were composed in hymns, *mantras* and propagated by word of mouth from one generation to other. These hymns again translated into poetry with proper rhyme and rhythm. The poetry ultimately translated into folk songs in different dialects for common man usage. In this way the complex idea of *vidvans* was rolled out to the common man in a most simplified manner. The same pattern can be traced to the tenants in the bible translated from hymns to fairy tales in the

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Christian religion and Quran in Islam. With the development of civilization and advancement of technology i.e., writing, painting, printing, photography, motion pictures and audio-recording etc. different forms of storytelling emerged to suit different media.

WHAT IS STORYTELLING?

Good Storytelling starts with a good story; without which the rest of the things will remain empty. A good story does not just mean an issue that is important for people to know about. It calls for rigorous thought as to who the key characters are, what the conflict is, how the story will play out, and how best to present different parts of the narrative form for maximum effect. Whether to create a fictional world or a nonfiction series about real people, the elements of what makes a good story don't change. The story is your opportunity to create characters that the audience can relate to and put them in situations where they are supposed to take decisions with respect actions to be taken as a consequence of those decisions.

How it works in our minds?

Our brains are wired to respond to stories, and they can influence our thinking and behaviors in several different ways. When we read someone else's story, we vicariously experience their challenges and learn by seeing the consequences of how they try to resolve the problems -- both positive and negative. Research has found that our brains light up in the same spots as the actions taking place in the story! When the character runs, the brain's "running center" is activated; when someone in danger, our own brain is becomes more alert.

This means that characters modeling positive behaviors in the story and being rewarded for it, or overcoming common setbacks, can be very effective. Stories can also establish or reinforce social norms that support the behavior you are promoting; if the characters make healthy food choices or practice physical activity in the course of the story, this can create the feeling that this is just what people do and so they should too. This is especially effective when the reader/viewer feels that the characters are very similar to themselves.

Immersive engagement for change:

In explaining how best to use this approach within the context of health and social change, Robert Pratton, used the term "immersive engagement" in pervasive entertainment. This model can be best described with the help of behavior change model, Good story telling, pervasive media, participatory experience and real world action. Our ultimate goal is to create an experience that leads our audience to take some action as a result of being engaged and motivated, whether it’s adopting a healthy or pro-social behavior, changing how they treat other people, helping the environment or actively joining a movement that aims to solve a social challenge. Awareness and education are necessary, but usually not sufficient by themselves to create real change. In addition to spreading messages and interventions across multiple media or platforms, it is also essential to find a way to grab the audience attention through the clutter.

In a long-term story-centered project, you can follow the Sabido Method, which has been used successfully for decades to drive development of entertainment education content and brings together behavioral, communication and learning theories. We can use other simpler models, such as social cognitive theory or the Fogg Behavior Model, but the crucial point is to understand the pieces that need to be in place in our story and in the structure of our project for change to happen. Start by identifying what you need to accomplish and how you intend to get there, by understanding what you need to include in the experience to effectively motivate the adoption of the key action(s).

We live in a transmedia world. information, stories, marketing come at us from all sides - from the radio news waking us up in the morning our lunch box describing the state of the *chapatis*; emails, texts and tweets with the latest updates from family, friends and co-workers; the billboards we see on the way to work; in-person meetings with our colleagues using the inevitable PowerPoint slides; our favorite TV show... We are bombarded with data that we constantly process on our course to create a coherent picture of our world. People we are trying to reach also live in this transmedia world. We need to reach people where they are, and where they are practically everywhere. Of course, your particular audience is more likely to spend their time in certain places than others, but don't assume that reaching them on one platform is enough to make an impression. The transmedia approach uses multiple platforms to convey different parts of a story (as opposed to the same story told over again via various media).

By posting the message in the places where the audience already spending their time, the story can seamlessly integrate into their daily routine. These touchpoints could be their mobile phone, their Twitter or Facebook stream, a link to a website, YouTube, email, snail mail, a comic book or location-based markers. The audience should encounter the content--whether fiction or nonfiction-based--alongside the other chunks of information to which they have chosen to pay attention, rather than making them go out of their way to find it. These selected platforms must work together to support the story strategically and synergistically based on their strengths and weaknesses, and how your audience uses them

A story should offer sufficient opportunities for the audience to go beyond just reading/watching/hearing what has been created, to enable them to participate by interacting with our content or - the Holy Grail - creating their own. While it's unrealistic to expect a majority, or perhaps even ten percent, of your audience to devote time to writing something or creating a video, be sure to offer ways to participate for those who are most enthusiastic about the story or project. This could be anything from playing an online game or solving a puzzle that moves the narrative forward, to interacting with characters on Twitter, role-playing a character in the story, connecting with others via a discussion forum to talk about the story or project, sharing their own real-life stories, attending a live (or virtual) event, entering a contest or other activities that bring people deeper into the story.

Real world experience:

There is no point in a social change project engaging people with stories that don't appeal their real world. Pervasive entertainment blurred the line between real-world and fictional world." (Pratten). This might mean having a character from the story send a text message to a participant's mobile phone, bringing the story off the page (or out of the computer) and into their real life. To take it a step further for social change, we also want the audience to draw the lessons from the story world (real or fictional) and apply them within the real world. If the story includes a young woman who models effective negotiation skills with her boyfriend when he doesn't want to wear a condom, we'd like to see the young women in our audience learn and apply those skills in their own lives. If the story highlights the problems faced by a village that does not have access to clean water, we can provide ways for our audience to get involved in providing clean water to others in a similar situation through supporting a particular nonprofit or joining a movement working toward solutions. The immersive context of the story means that it touches people's lives wherever they may be.

SOCIAL MEDIA & STORY TELLING

Social media has opened up many storytelling opportunities, particularly for health education, because of its ease of use and low cost. Social media sites provide a variety of features that serve different purposes for the individual user. These include blogs, social networks, video- and photo-sharing sites, wikis, or a myriad of other media, which can be grouped according to purpose, serving functions such as:

- Social networking (Facebook, MySpace, Google Plus, Twitter)
- Professional networking (LinkedIn)
- Media sharing (YouTube, Flickr)
- Content production (blogs [Tumblr, Blogger] and micro blogs [Twitter])
- Knowledge/information aggregation (Wikipedia)
- Virtual reality and gaming environments (Second Life)

Participation in social media by the general public has increased sharply over the past few years. Social media have been linked to highly significant political events, such as the Arab Spring revolution, as well as to widespread societal trends, including the shortening of individuals' attention spans and the decline of print news media.

Social media provide Health Care Professionals (HCP) with tools to share information, to debate health care policy and practice issues, to promote health behaviors, to engage with the public, and to educate and interact with patients, caregivers, students, and colleagues. HCPs can use social media to potentially improve health outcomes, develop a professional network, increase personal awareness of news and discoveries, motivate patients, and provide health information to the community.

Health Care Professionals most often join online communities where they can read news articles, listen to experts, research medical developments, consult colleagues regarding patient issues, and network. There they can share cases and ideas, discuss practice management challenges, make referrals, disseminate their research, market their practices, or engage in health advocacy. A growing minority of physicians also uses social media to communicate directly with patients to augment clinical care.

When used wisely and prudently, social media sites and platforms offer the potential to promote individual and public health, as well as professional development and advancement.(2)

CONCLUSION

Storytelling is one approach of many that can make it more likely that someone will take action. It can happen face-to-face, though books, videos, audio, comics and any of the other myriad ways people communicate with each other. When you combine different media, and tell stories from alternate points of view, it gets even more interesting. Storytelling is a powerful tool to bring about health and social change, when it is combined with proven behavior change models-social marketing and entertainment education principles, it has the potential of radical transformation of social norms with the help of transmedia approach i.e., using different platforms for telling different parts of a story rather than the same story told over and over again via various media.

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Gender Based Differences: An Overview of Mental Health

Dr. Suhina Chatterjee[1]*

ABSTRACT

The study was aimed to investigation the effect of mental health on male and female students. Mental Health Inventory was administered on 50 early adolescents (25 male and 25 female) from different schools of Ranchi. These two groups were further divided according to their socio-economic status. Data was analyzed using mean, standard deviation and‘t’ value. The findings revealed that there was significant difference between male and female students on their mental health level. Male students are more mentally healthy than female students (‘t’=7.48., P<.01). Result further revealed that socio-economic status has no significant effect on mental health.

Keywords: *Mental health, Gender, Socio-economic status.*

Mental health as a state of prosperity in which everyone sees himself as an able and talented person and they can cope with the normal stress of their life. Mental health describes our social, emotional, and psychological states, all wrapped up into one. Someone who experiences “good” mental health, therefore, has found a balance in his or her social, emotional and psychological areas of life.

According to Negi (2010) mental health is balance between all aspects of life- social, physical and spiritual aspect of a person. It imparts on how we manage our surroundings and make choices in our lives clearly it is an integral part of our overall health.

The WHO constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important consequence of this definition is that mental health is described as more than the absence of mental disorders or disabilities. Bhatia (1982) considers mental health as the ability to balance feelings, desires, ambitions and ideals in one's daily living. It means the ability to face and accept the realities of life.

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According to Kornhouser(1965) "Mental health is those behaviour, perception and feeling that determine a person‟s overall level of personal effectiveness, success, happiness and excellence of functioning as a person."

The aim of this work is to discuss gender differences on mental health; a gender approach to health means to distinguish biological and social factors while exploring their interactions and to be sensitive to how gender inequality affects health outcomes.

Srivstava (1987) found that mental health of female teachers is significantly lower than that of male teachers. Indian women have been gradually coming out of traditional roles and entering into the male dominated areas. In recent years the role and status of the women have been changed tremendously. Research review highlight that women are trapped in a situation where they are getting difficulty in coping strategies to deal with it effectively and get mentally strained. Brunette & Drake (1998) reported that women experience higher rates of mental illness than men.

Socio-economic status is also related to harmful inequalities in mental health.
There are various material and psychosocial reasons why people living in disadvantaged areas experience poorer health. For example, low income can negatively impact housing standards or reduce access to medical services; low educational attainment can affect the ability to obtain information on health services and health risk prevention; and the lack of a sense of financial security or control over one's life may create chronic stress which can negatively impact on physical as well as mental wellbeing.

According to Bradley (2002) children with low socio-economic status more often manifest symptoms of mental disorders. Desjarlais et al.,(1995) shown that mental illness is more common among people with some social disadvantage.

Ustin et ,al.,(1986) found that DSM-III disorder was higher in the lowest socio-economic status category than in the highest.

We all have mental health just like we all have physical health. And just as we monitor our bodies for potential problems or pain, we should keep tabs on our mental health and try to better recognize when it needs some attention.

Hypotheses

Some hypotheses were framed for verification:-

1) Male and female students will differ significantly in their mental health level.
2) There will be significant difference between high and low socio-economic groups of students in their mental health level.

Sample:-

Fifty government school students were selected as sample of the study. These students were taken from different government schools of Ranchi district. 25 males and 25 female students were taking as sample. These two groups were further divided according to their socio-economic status (parental education and income). The sample was selected by stratified random sampling technique.

Tools:

In order to measure and assess the level of mental health of male and female students following tools were used.

1) **Personal Data questionnaire-** Personal data questionnaire developed by researcher. It included the information about each student's name, age, class, sex, parental income, education, name of the school etc.
2) **Mental Health Inventory-** Mental health battery developed and standardized by Arun Kumar Singh & Alpana Sengupta (2008) was used to study the mental health of the adolescents. Reliability and validity also available in this scale.

Procedure:-

Mental Health Inventory was administered on 50 students of Government schools of Ranchi district. After collection of data the response sheet was scored individually for each subject. In order to fulfill the hypotheses of the study, the score obtained were analyzed with means, SDs and 't' values.

RESULT AND DISCUSSION

Table-1, No and percentage of total students in mental health inventory

Level	Scores	No of students	Percentage
Excellent mental health	70-90	42	84%
Average mental health	50-69	8	16%
Poor mental health	0-49	0	0%

It is evident from the above table that 84% students were found to have good mental health, 16% were under average and 0% students having poor mental health.

Table-2, Means, SDs and t values of male and female school students on mental health score.

Gender	Number	Means	SDs	MD	't'	P value
Male	25	75.92	8.50	19.08	7.48	P<.01
Female	25	56.84	9.50			

A glance at the table-2 shows that male students scored higher than females yielding a value of 't' ratio 7.48 (P<.01). Thus it can be said that male group is more mentally healthy than female group of students. The reason may be linked with environmental and cultural factors. Females are expected to be good in both household world and studies. They are hardly allowed to show

their emotional burst, anger and rage. Therefore, emotional balance, adjustment process, tolerance level and other personality attributes are under great threat, which affect negatively the mental health. The present finding is supported by the earlier studies conducted by Takahiro et.al, (2012).

Table-3, Means, SDs and t values of high and low socio-economic group of school students on mental health score.

Group	Number	Means	SDs	MD	't'	P value
HSES	20	78.9	8.50	4.4	1.94	NS
LSES	20	74.5	7.78			

The findings shown in table-3 that high socio-economic group of students have more mentally healthy (Mean= 78.9) than low socio-economic group of students (Mean= 74.5) but this difference is not statistically significant ('t'=1.94).

MAIN FINDINGS

The main findings of the study were:-

1) Majority of the students have good mental health (84%).
2) Males were found to be more mentally healthy than females.
3) High & low socio-economic groups were not differing significantly on their mental health score.

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Risk Taking Behaviour and Career Choice among Youth Aspiring to be an Officer in Indian Armed Force

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ABSTRACT

Due to profusion of opportunities, varied trends of job market and perceived risk associated with career as Officer in Indian Armed force has made it unpopular and unattractive among many adolescents. Rapid economic growth and changing social norms in the society have certainly divided adolescents into aspirants and non-aspirants for this career choice. Career in armed force is characterised by its dynamic nature and pride associated with it. A study was carried out to investigate as whether risk taking behaviour has a role in aspiring to become armed force officer. Studies in past has revealed many factors affecting a career preference such as educational qualification, aptitude, intellect, father's occupation, interest and many more. In this study risk taking behaviour has been investigated between aspirants and non-aspirants. The result showed that aspirants have more risk taking behaviour than non-aspirants especially in fire and military services areas which demands more risk taking orientation.

Keywords: *Behaviour, Career Choice, Youth, Indian Armed Force.*

The aspiration of career is generally reflected by the stream of subject chosen by an individual after class tenth, which enables one to choose only bunch of careers after attainment of qualification or degree. The issue of career choice has been studied in past at length highlighting various factors affecting it. Each individual undergoing the process of making a career choice is influenced by such factors as the context in which they live, their personal aptitude, educational attainment, father's occupation, intellect and ability (Bandura et. al. 2001; Watson et. al. 2010; Pascual,N.T. 2014)

Making career choice in Indian armed force as an officer is one of the career in the multitude of option available which is unpopular and unattractive among many, despite that some found this career as their life time dream aspiration. Considering rapid changes in socio-economic aspects, job opportunities, fluctuating personal and institutional trends, publicity and dynamism in the

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Indian society, generally a bipolar choice for this career has been observed i.e. either aspirants or non-aspirants at all. This career choice is either aspired because of honour and pride associated with it or role of something else also play into it? It is either non-aspired because of mental and physical hardships involved or role of something else also play into it? Many aspect of personality can make an individual aspired or non-aspired to this career. Hence, a study with an objective was undertaken to determine the difference in risk taking behaviour in relation to aspiration towards the armed force career. A study by Rita, B & Thilagavathy, T (2015) on 800 graduate students found that risk taking behaviour was average among them.

Risk is product of the probability of an event occurring that may be viewed desirable or undesirable, and subjective or objective assessment of the expected or unexpected consequences from the event occurring, how much and in what way an outcome provides utility in terms of physically, socially, culturally or individually. Hence, risk is part of every Endeavour. It can be depicted as in following equation:

Risk = Probability of an event X Consequence X Utility

The genetic determinant (Zuckerman 1994a), gender differences (Weber, Blais, and Betz, 2002), and role of nurture (Booth & Nolen, 2008), in risk taking behaviour had been studied in detail. Some Indian studies had also been undertaken to explore the risk taking behaviour such as a study conducted on 250 male higher secondary students from Manipuri district, it was found that biographical factors (caste, locale and family type) do not affect the risk taking behaviour (Gupta & Chauhan, 2015). Similar results were reported by the study of Pandian & Ramachandran (2011).

Hypothesis

1. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in risk taking behaviour.
2. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in hill area of risk taking behaviour.
3. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in space area of risk taking behaviour.
4. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in sea area of risk taking behaviour.
5. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in commercial trade area of risk taking behaviour.
6. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in police and intelligence service area of risk taking behaviour.
7. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in fire area of risk taking behaviour.

8. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in professional trade area of risk taking behaviour.
9. There will be no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in military services area of risk taking behaviour.

METHOD

Sample

A sample of 108 subjects ranging between age of 18 to 22 years had taken the risk taking behaviour questionnaire. Fifty eight subjects were Indian Armed Force aspirants and fifty subjects were non-aspirants to join Indian Armed Force. Both groups of subject were from urban and middle socio-economic status. The aspirant subjects were who aspired to be an armed forces officer reported to services selection board to Bhopal centre and non-aspirants were also from Bhopal who were not at all or not willing in future to aspire for career as an officer in Indian armed force. We can differentiate between them as reported applicants and non willing applicants to this career. Both groups have been equated in terms of sex, age, socio-economic status, demographic and academic qualification.

Measure

Risk taking questionnaire (RTQ) developed by Sinha, V. & Arora, P.N. (1983) was used. This questionnaire has been designed to measure the extent of 'risk' taken by a particular individual in his personal as well as in his social life. Eight areas of risk were included in the test, which were considered to be the most important and affiliated of risk for Indian life. These areas were

a) Hills.
b) Space.
c) Sea.
d) Commercial trades.
e) Police and intelligence service.
f) Fire.
g) Professional trades.
h) Military service.

The risk taking questionnaire consists of 40 items (five items for each area). It takes about 30 minutes on an average to complete it. The answering of RTQ is based on a Five Point scale. The candidate was asked only to tick the category liked by him. The candidate was asked to "Tick 'very much' category, if he/she like very much the thing, mentioned in the particular item." In the same way tick out in the "much moderate 'less', and very less categories as one think fitness to oneself about the statement given in the item. In RTQ, the five leaning categories i.e. very much, much, moderate, less and very less carry the 5, 4, 3, 2, 1 scores respectively. The sum of the scores in all the eight areas gives the total extent of risk-tendency in an individual. The RTQ is capable to sort out the risk-taking tendency in any one particular area. The maximum possible score in the tool was 200 and the minimum scores were 40 only. The reliability coefficient of the

questionnaire was found 0.79 for 14-20 years old urban male adolescents. The area wise reliability was also computed as following;

Reliability coefficients	Areas of risk taking questionnaire (urban male adolescents : 14 – 20 years old)							
	1	2	3	4	5	6	7	8
r	.39	.58	.75	.75	.79	.56	.49	.63
p	.01	.01	.01	.01	.01	.01	.01	.01

Procedure

Subjects who have appeared before services selection board at Bhopal centre were briefed about the study and consent was sought. Thereafter they were requested to complete the risk taking questionnaire in group testing. A checklist of career choice including armed force career was administered to the school students of Bhopal. The subject who does not opt armed force career option in the checklist form part in the second group i.e. non-aspirants to armed force career. After briefing them about the objective of the study and reassuring individually about fulfilling the criteria, risk taking questionnaire was individually administered to them. Subjects of both groups were assured about confidentiality of responses.

RESULT

The table 1 reveals that t value 2.54 for 103 df, the .05 level was 1.98 and .01 level was 2.63, since t value reached more than .05 level but less than .01 level, therefore the obtained mean difference was found significant at .05 level but not at .01 level. Thus null hypothesis was rejected implying that there was a significant difference between career choice as Indian Armed Force aspirants and non-aspirants in risk taking behaviour. The mean score of aspirants (161.21) was found higher than non-aspirants (153.8). The spread of scores from mean was more in non-aspirants (16.32) than aspirants (13.9).

Table 1

Risk Taking Behaviour	Career choice (Indian Armed Force)	N	Mean	S.D.	t	df	Level of significance	Null Hypothesis
Total	Aspirants	58	161.21	13.9	2.54	103	.05 Significant	Rejected
	Non-Aspirants	50	153.8	16.32				

From table 2, t test values for 103 df, the .05 level was 1.98 and .01 level was 2.63. The null hypotheses as stated that there was no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in 'fire and military services' areas of risk taking behaviour were rejected. The null hypotheses for the areas of risk taking behaviour namely, hills, space, sea, commercial trades, police intelligence services and professional trades (except fire and military services areas) were accepted, implying that there was no significant difference between career choice as Indian Armed Force aspirants and non-aspirants in 'hills, space, sea, commercial trades, police intelligence services and professional trades' areas of risk taking behaviour.

Table 2

S.No.	Areas of Risk Taking Behaviour	Aspirants (N = 50) Mean	S.D.	Non-Aspirants (N=58) Mean	S.D.	t value	df	Level of Significance	Null Hypothesis
1	Hills	19.63	3.42	19.22	2.65	0.7	103	.05 / NS	Accepted
2	Space	20.01	3.00	19.28	3.27	1.22	103	.05 / NS	Accepted
3	Sea	20.58	2.24	19.92	2.42	1.48	103	.05 / NS	Accepted
4	Commercial Trades	16.34	3.39	16.16	3.45	0.28	03	.05 / NS	Accepted
5	Police and Intelligence Service	20.70	2.62	19.64	3.77	1.72	103	.05 / NS	Accepted
6	Fire	20.43	2.33	19.44	2.76	2.02	103	.05 / Significant	*Rejected*
7	Professional Trades	20.60	2.63	19.40	3.90	1.90	103	.05 / NS	Accepted
8	Military Service	22.87	2.35	20.74	4.15	3.34	103	.01 / Significant	*Rejected*

NS – not significant

CONCLUSION

In this study we had aimed to investigate the role of risk taking behaviour in aspiring career to become an officer in Indian armed force. On the basis of results the three null hypotheses were rejected. Thus there was significant difference between two groups (Indian armed force career aspirants and non-aspirants) on risk taking behaviour both in total as well as its areas of risk taking behaviour, namely fire and military services. The mean of aspirants were found higher on risk taking behaviour both in total as well as 'fire and military services' areas of risk taking behaviour than non-aspirants. For remaining areas of risk taking behaviour namely, hills, space, sea, commercial trades, police intelligence services and professional trades, there were no significant difference between career choice as Indian Armed Force aspirants and non-aspirants.

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Academic Achievement of Adolescents in Relation to Study Habits

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ABSTRACT

The purpose of the present study was to find out the relationship between academic achievement and study habits of adolescents. A representative sample of 100 students studying in 9th class was randomly selected from senior secondary schools of Ludhiana district of Punjab (India). Marks obtained by the adolescents in previous annual examination were taken as an index of Academic Achievement .Study Habits Inventory by Dr. N.S Yadav has been used for data collection. Data was analyzed by using t-test and coefficient of correlation. The result indicates that there is a strong positive correlation between academic achievement and study habits of adolescents.

Keywords: *Academic Achievement, Adolescents, Habits.*

Education is an activity or process, which modifies the behavior of a person from instinctive to human behavior (Taneja, 2003, p.9). This definition reveals the innate truth that education aims at discovering aptitudes as well as to progressively prepare man for social activity; because of this, education through which the basic needs (food, shelter and clothing) are provided is necessary for the survival of the society. The general belief is that students who exercise good study habits are likely to excel than those with poor study habits. According to Sharma (2005, p.67)" academic performance is a necessary evil because one kind of ability is rewarded economically and socially more than others." This necessitates concern over factors that are commonly linked with academic achievement. There is tremendous pressure on students to earn good grades because academic achievement is assumed to possess predictive value and used to bar the gate or to open between the primary, secondary schools and university, and also between the university and certain social professions (Sharma, 2005, p.69)

Academic Achievement

Academic Achievement generally refers to the degree or level of success or proficiency attained in some academic work. It encourages the students to work hard and learn more. Academic achievement is the status of a student's learning and refers to knowledge attained and skills

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developed during their academic career which are assessed by school authorities with the help of teacher made or standardized tests.

Academic achievement is one of the most important goals of education. The success or failure of a student is measured in terms of academic achievement. It means development of skills in school subjects. Academic Achievement is the criterion for selection, promotion or recognition in various walks of life. Academic Achievement is based on the assumption that there are differences within an individual from time as behavioural oscillations. The academic achievement of the same individual differs from time to time, from one class to another and from, one educational level to another. Kumari Sushma (2001)-defined academic achievement as the sum total of information gained after completing a course of instruction (partially or fully) in a particular grade that he has obtained on an achievement test. Academic Achievement is one part of the wider term of educational growth. It refers to what a student has achieved in different subjects of studies, during the course of academic year. Academic achievement is affected largely due to the intra individual differences, (differences within the individual from time to time) or with individual differences, i.e. between one individual and another, between one group and another. Besides areas of functioning, individuals of the same group, same grade and same potential ability may differ in their academic proficiency due to many factors. At each stage in the schools some measure of achievement is used as determiner of the student's status and as a basis for decisions about the further opportunities for learning to be provided in subsequent stages. In the present context of education, achievement in academic subjects is the main concern of the teachers, students and parents. The scholastic attainment is the basis of selection and differentiation among students for different openings and avenues of advancement in various fields.

Study Habits

Study habits have been defined as the sum total of all habits of determined purposes and enforced practices that the individual uses in order to learn. It is necessary for the students to develop special study habits and skills. A well formed habit furnishes its own sources of motivation As such the word ‘Study habits’ comprised of two words: ‘study’ and ‘habits’. According to English and English, habit is an acquired act, usually relatively simple one that is regularly or customarily manifested and study is relatively protracted application to a topic or problems for the purpose of learning about the topic. Solving the problem or memorizing part or all to the presented material.

Study habits is a well planned and deliberate pattern of study, which has attained a form of consistency on the part of the students towards understanding academic subjects and passing examination (Pauk, 1962; Deese, 1952; Akinboye, 1974 cited by Oyedeji). Therefore, study can be interpreted as a planned program of subject matter master. According to Crow and Crow, (2007), the chief purposes of study are: to acquire knowledge and habits which will be useful in meeting new situations, interpreting ideas, making judgments creating new ideas and to perfect

skills. Therefore, successful achievement in any form of academic activity is based upon study, interpretation and application. Everyone has different study habits. All often, students perform poorly in school simply because they lack good study habits. In many cases, students do not know where to begin. Those students in high school who succeed especially well usually study alone and follow a study technique that has been worked out by them and that incorporates desirable procedures. Good health, sufficient sleep, appropriate exercise and nutritious diet are essential to achievement of good study results. Study conditions that are unfavorable include inadequate lighting, extremes of temperatures, humidity, poor posture, subnormal physical conditions and emotional disturbance. Although habits differ from person to person, some general principles can be derived about studying efficiently. Here are some good study habits that lead to better academic achievement.

1. Attending classes regularly
2. Taking down notes during teaching
3. Concentrating on study
4. Studying with aim of getting meaning not cramming
5. Preparing a time table
6. Following a time table
7. Having proper rest periods
8. Facing the problems regarding home environment and planning.
9. Facing the challenges posed by school environment
10. Keeping daily survey of work done

Study habits vary from student to student. Some habits are considered to be more desirable than others from the point of view of academic achievement. Crow and Crow (2007, p.261)"s *Educational Psychology* states that study requires a purpose and what one learns as a result of study depends largely upon the degree to which one succeeds in achieving that aim or purpose. Child (1981, p.95) "s *Psychology and the Teacher* asserts that we talk about forming bad or good habits in many everyday activities in both social and educational contexts. We behave, by and large, in characteristic ways because we have discovered through experience that some responses are more effective than others.

Sawar et al. (2009) in their analysis on "Study Orientation of High and Low Academic Achievers at Secondary School Level on Pakistan" revealed that the high achievers had better study orientation, study attitude than the low achievers.

NEED AND SIGNIFICANCE OF THE STUDY

Achievement is the end-product of all educational endeavors. The main concern of all educational efforts is to see that the learner achieves. The distressing phenomena: scholastic underachievement and failure have caused serious concern to educationists, guidance counselors and educational planners for several decades as this amount to colossal wastage of resources available for education. "This necessitates serious probe into the causes that underlie and factors that lead to underachievement and failure, so that means could be devised to grapple with this

enormous problem (Mishra and Danga 2005).**"** The failure rate in various examinations may depend on many factors but one of the main reasons is poor or ineffective study habits. Now days students do not devote sufficient time to their studies and seldom have proper study habits. It is felt that students with good study habits are better than others. It is important to have a clear understanding of what benefits or hinders one's educational achievement. This is the premise on which this study is justified

Statement of the Problem

ACADEMIC ACHIEVEMENT OF ADOLESCENTS IN RELATION TO STUDY HABITS

OBJECTIVES OF STUDY

The objectives of the study were as follows.

1. To compare the academic achievement of male and female adolescents.
2. To compare the academic achievement of rural and urban adolescents.
3. To compare the study habits of male and female adolescents
4. To compare the study habits of rural and urban adolescents.
5. To find out the relationship between academic achievement and study habits of adolescents.

Hypotheses

As per the objectives of study, the present study was undertaken to test the following hypotheses.

1. There is no significant difference between academic achievement of male and female adolescents.
2. There is no significant difference between academic achievement of rural and urban adolescents.
3. There is no significant difference between the study habits of male and female adolescents.
4. There is no significant difference between the study habits of rural and urban adolescents.
5. There is no significant relationship between academic achievement and study habits of adolescents.

Design of the Study

In the present study, descriptive survey method was employed to investigate the relationship between academic achievement and study habits of adolescents.

Sample

The study was conducted on 100 students (50 boys and 50 girls) of 9th class which were randomly selected from rural and urban senior secondary schools of Ludhiana District.

Tools Used

1. Marks obtained by the adolescents in the previous annual examination were taken as an index of Academic Achievement.
2. Study Habits Inventory by Dr. N.S Yadav

Statistical Techniques Used

Mean, S.D, t-test and Karl Pearson's coefficient of correlation were used for analysis of the data.

ANALYSIS AND INTERPRETATION OF THE DATA

Table 1, Academic Achievement of Male and Female adolescents

Category	No. of students	Mean	S.D.	t-ratio
Male	50	59.62	4.27	7.33
Female	50	68.82	7.76	

Significant at 0.01 level

Table 1 shows the mean, standard deviation and t-ratio of academic achievement of male and female adolescents. The calculated mean scores of male and female adolescents are 59.62 and 68.82 respectively. The t-ratio is 7.33 which is significant at 0.01 level. Hence hypothesis *there is no significant difference in academic achievement of male and female adolescents* stands rejected at 0.01 level.

Table 2, Academic Achievement of Rural and Urban adolescents

Locale	No. of students	Mean	S.D.	t-ratio
Rural	50	61.92	5.73	3.089
Urban	50	66.52	8.84	

Significant at 0.01 level

Table 2 shows that the mean scores of academic achievement of rural and urban adolescents. The calculated mean scores of rural and urban adolescents are 61.92 and 66.52 respectively .The mean score of urban adolescents is more than that of rural adolescents. The t-ratio is 3.089 that indicates that the difference between the two mean scores is significant at 0.01 level. Hence hypothesis *there is no significant difference between academic achievement of rural and urban adolescents* stands rejected.

Table 3, Difference between study habits of male and female adolescents

Category	No. of students	Mean	S.D.	t-ratio
Male	50	214.34	18.32	5.40
Female	50	234.72	19.36	

Significant at 0.01 level

Table 3 shows that the mean score of study habits of male adolescents is 214.34 with S.D. as 18.32 and mean score of female adolescents is 234.72 with S.D. as19.36. The mean score of study habits of girls is higher than the mean score of study habits of boys. The t-ratio is 5.40 which is significant at 0.01 level. So it is found that study habits of girls are better than the study habits of boys. Hence the hypothesis that *there is no significant difference between study habits of male and female adolescents* stands rejected at 0.01 statistical level.

Table 4. Difference between study habits of rural and urban adolescents

Locale	No. of students	Mean	S.D.	t-ratio
Rural	50	217.96	20.26	3.217
Urban	50	231.1	20.589	

Significant at 0.01

Table 4 shows that the mean score of study habits of rural students is 217.96 with S.D. as 20.26 and mean score of urban students is 231.1 with S.D. as 20.589. The mean score of study habits of urban students is higher than the mean score of study habits of rural students. The t-ratio is 3.217 which is significant at 0.01 level. So it can be concluded that study habits of urban student are significantly better than the study habits of rural students. Hence the hypothesis that *there is no significant difference between study habits of rural and urban adolescents* stands rejected at 0.01 statistical level.

Table 5, Correlation between Academic Achievement and study habits of adolescents

Variable	N	Correlation
Academic Achievement	50	0.735
study habits	50	

Table 5 represents the coefficient of correlation between academic achievement and study habits of adolescents. The value 0.735 indicates that there is positive and highly significant correlation between academic achievement and study habits of adolescents. Hence the hypothesis *there is no significant relationship between academic achievement and study habits of adolescents* stands rejected..

FINDINGS OF THE STUDY

- There is significant difference between academic achievement of male and female adolescents.
- There is significant difference between academic achievement of rural and urban adolescents.
- There is significant difference between the study habits of male and female adolescents.
- There is significant difference between the study habits of rural and urban adolescents.
- There is significant positive relationship between academic achievement and study habits of adolescents.

CONCLUSION

In the educational parlance, performance manifests through academic achievement, which is the manifestation of a student's habit of study and they in turn are formed and strengthened through education. The development of good study habits is equally relative and helpful not only in academic work but in career actualization. And because this interrelationship cannot be overlooked, the academic achievement and study habit of the student to a large extent culminates into shaping an individual destiny. Proper study habits should be inculcated and nurtured at the very young age of the child. Efforts should be made both by the parents as well as by the school authorities to provide congenial environment to develop good habits among the children so that academic failure is to be forestalled and standards improved,

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Cognitive Behaviour Therapy in Forensic Setting: An Overview

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ABSTRACT

The increase in need of treatment services in prison has been in great demand. The augmented number of crimes ranging from petty crimes to serious heinous crimes in last two decades brought in the requirement of mental health facilities in prisons at the surface level. Growth in prison facilities and prisoner populations has outstripped the slower growth in mental health services, and become the need of an hour to appoint the trained and experienced therapist to reduce the rate of recidivism. Psychotherapy one of the facility in forensic setting, has been proved as an efficient method in recidivism. Among the various therapies administered on offenders, Cognitive Behavioural Therapy (CBT) includes numerous programs like anger management therapy, moral reconation therapy, reasoning and rehabilitation, soft skill training, substance abuse training, relapse prevention therapy etc. are considered as the important component of the mental health facilities in the prisons, correctional and observation homes with an aim to increase the community re-entry of the offenders. CBT in prison focuses on cognitive functioning and behaviour especially on developing skills for living in harmony with the community and engaging in behaviours that contribute to positive outcomes in society. In the light of the available applications of CBT on forensic population, the heed of this article is to provide an overview of the effectiveness in crime reduction and training the offenders for becoming an acceptable member of the society.

Keywords: *Mental health facilities, cognitive behaviour therapy (CBT), recidivism, community re-entry.*

Psychotherapy is considered as one of the forms of the treatment which is employs the systematic use of a therapeutic relationship between therapist and patient where the former tries to bring in the changes within the latter. This is considered a totally distinct approach from the pharmacological where psychiatrist tries to bring the changes in behaviour or to produce change

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in feelings, thinking of the individual by prescribing medicines. Psychotherapy has been defined in many ways but most acceptable definition defines it as the "Psychotherapy is an interpersonal, relational intervention used by trained psychotherapists to aid clients in problems of living and coming out of the problems in the end". The advantage of this definition is that it highlights how the quality of the interpersonal relationship forms the basis for therapeutic efficacy, and how it focuses on bringing out the changes as an end result of the interaction. All the ways in which psychotherapy has been defined, interpersonal relationships, communication is a key and intrinsic component of psychotherapy. This communication predominantly involves the use of spoken language along with few non-verbal communications and gestures e.g. body sculpting,drama, music, art and play. Moreover, psychotherapists includes a range of techniques based on experiential relationship building, dialogue, communication and behaviour change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family).

In the process of psychotherapy, therapist generally view change as a by-product of empathic listening and beneficial presence which are the prominent feature of this process wherein the clients are less likely to explicitly intervene to effect intended changes. Despite the diversity of techniques employed in psychotherapy, the following are beneficial functions that most, if not all effective psychotherapies have in common like developing a therapeutic relationship, generating positive expectations, facilitating cognitive and experiential learning, facilitating emotional arousal and catharsis, engendering a sense of mastery and finally the application of new skills developed.

Levels of Psychotherapy

To speak of the varying levels in psychotherapy, suggests that intended changes for patients may be superficial, intermediate or deep. Psychoanalysis, with its ambitious goal of reconstructing character pathology by dealing with deep, hidden psychic issues from the past, and its frequency and duration of meeting with the patient, is taken as the deepest extent of psychotherapeutic exploration. The corollary is that techniques that rely less on psychoanalytic methods (e.g. exploration of the unconscious by free association, interpretation of the unconscious conflicts and transference) and forms of psychotherapy in which patients are seen less often or for shorter periods of time are assumed to have only modest effects. Thus, activities such as the unburdening of problems to a sympathetic listener, ventilation of feelings to a supportive helper, rational discussion of problems with the aim of arriving at practical solutions and having more information are presumed to fall short of what could be achieved through deep exploration and analysis.

In a different sense, the level of psychotherapy could be used to indicate the level of training and sophistication of the practitioner. This ranges from 'level 1' of basic counselling, through an intermediate 'level 2' practised by many psychiatrists, psychologists, social workers and nurses,

to specialist 'level 3' treatments. The assumption here is that the 'level 3' specialists have better skills and can deal better with more difficult clinical situations.

Cognitive-Behavioral Therapy (CBT) in Forensic Setting

Cognitive-behavioural (CB) theory and approaches emerged from two paths: cognitive theory and therapy and behavioural theory and therapy. The development of behavioural therapies in the late 1950s and 1960s provided the foundation of the behaviour component of cognitive-behavioural therapy.

Behavioural therapies and Cognitive-restructuring approaches seemed to develop in parallel paths, over time the two approaches merged into what we now call *cognitive-behavioural therapy* (CBT). Bandura's work on behavioural modification, social learning theory, and how internal mental processes regulate and modify behaviour provided an important bridge in the merging of behavioural and cognitive approaches (1995,1996).

Following the work of Ellis and Beck (A. Beck, 1963, 1970, 1976), the different approaches to cognitive therapy and cognitive restructuring were joined with the elements of behavioural therapy. Examples of this blending (coming together) include coping-skills training and self-instructional training (Meichenbaum, 1975, 1977). Other blending approaches include problem solving, assertiveness and other social skills training, and managing relationship stress. Most cognitive approaches see the process of treatment as starting with helping the client to identify automatic thoughts and cognitive distortions and then addressing the long-term underlying core beliefs that are associated with them (J. Beck, 1995; Dobson and Dozois, 2001; Freeman et al.,1990; Leahy, 1997).

Contemporary CBT, is an integration of the key components of behavioural and cognitive therapy. It is common to see cognitive restructuring as the cognitive part of CBT and social skills training as the behavioural component of CBT. An important combining element of CB approaches is the principle of *self-reinforcement.* This concept simply states that cognitive and behavioural changes reinforce each other. When change in thinking lead to positive behaviour outcomes, the outcomes strengthen both the behaviour and the cognitive structures that lead to those outcomes. In turn, the changes in thinking reinforced by the changes in behaviour further strengthen those behavioural changes. It is not just the reinforcement of the behaviour that strengthens the behaviour; it is the reinforcement of the thought structures leading to the behaviour that strengthens the behaviour.

Effective cognitive-behavioral programs of all types attempt to assist offenders in four primary tasks: (1) define the problems that led them into conflict with authorities, (2) select goals, (3) generate new alternative prosocial solutions, and (4) implement these solutions (Cullen and Gendreau, 2000).

Generally, cognitive-behavioral therapies in correctional settings consist of highly structured treatments that are detailed in manuals (Dobson and Khatri, 2000) and typically delivered to groups of 8 to 12 individuals in a classroom-like setting. Highly individualized, one-on-one cognitive-behavioral therapy provided by mental health professionals is not practical on a large scale within the prison system (Wilson, Bouffard, and Mackenzie, 2005).

Goals of CBT: Clinical setting versus Forensic setting

The major types of therapies predominantly used in clinical setting are psychoanalytic therapy that focuses on bringing out the repressed and subconscious and unconscious thoughts, feeling, unfulfilled desires to the surface and conscious level; Cognitive-Behavioural Therapy focuses on modifying the cognitive distortions and maladaptive behaviours of the client especially in the case of depression. On the other hand Interpersonal or systemic therapy is the means to bring about change, with the aim of helping patients to improve their interpersonal relationships or change their expectations about them. And lastly, Existential or gestalt philosophy aims to help client to establish what it is that matters to him/her, so that s/he can begin to feel more in tune with him/herself and therefore more real and alive. In general, psychotherapy aims to provide the solution to the problems that are faced by the clinical population. In clinical setting, psychotherapies targets and works for removal of distressing symptoms of the client, altering disturbed patterns of behaviour along with improved interpersonal relationships. It also aims to teach the better coping with stresses of life and lastly focusing on the personal growth and maturation. The desired changes in the client can be achieved in many ways i.e there are various types of psychotherapies that targets the specific types of the problems encountered by the client.

As the major focus of this article is on effectiveness of the CBT in on forensic population, when same approach is targeting the offenders (juveniles, adult, violent, sexual, female offenders, substance abusers etc.) to bring down the rate of recidivism, it has been found to be the most effective therapy. The end product of this therapy helps the offender for community re-entry with less chances of reoffending. CBT involves building attitudes and skills that are required to be morally responsible and to develop empathy along with allowing the offenders to develop insight for the welfare and safety of others (Little, 2000, 2001; Ross and Fabiano, 1985; Wanberg and Milkman, 1998). CBT in forensic setting employs the programs such as Aggression Replacement Training(ART), Criminal Conduct and Substance Abuse Treatment, Strategies for Self-Improvement and Change (SSC), Moral Reconation Therapy(MRT), Reasoning and Rehabilitation, Relapse Prevention Therapy (RPT) and Thinking for a Change (T4C) etc. that targets the maladaptive behaviour and finally leading to adaptive behaviour. The outcome of these programs must include an approach that focuses on making the offender to understand his/her responsibility toward others and the community by laying an emphasis on empathy building, victim awareness, victim empathy, social conditioning especially in juvenile offenders and developing attitudes that show concern for the safety and welfare of others. It also includes helping offenders inculcate the belief that when a person engages in behavior that is harmful to others and society, they are violating their own sense of morality (Wanberg and Milkman, 2006).

Using the above mentioned programs as an important part of the therapy, therapy as a whole targets on following mental health problems are most commonly linked to offending behaviour:

a) Personality disorder: particularly of the antisocial variety, but often combined with other personality disorders, commonly borderline and narcissistic types,
b) Anger and associated problem.
c) Substance abuse and increasingly poly-substance abuse: Individuals may regularly take a wide range of substance; often the pattern of use depends on availability.
d) Sexual offending; the range of offences referred for psychological intervention commonly includes rape and paedophilia.
e) Post traumatic disorder.
f) Compulsive behaviour, individuals who engage in compulsive behaviour such as shoplifting and gambling are often in conflict with the law.

How it is useful in forensic fields

Six cognitive- behavioural programs are widely used in the criminal justice systems namely Aggression Replacement Training(ART), Criminal Conduct and Substance Abuse Treatment, Strategies for Self-Improvement and Change (SSC), Moral Reconation Therapy(MRT), Reasoning and Rehabilitation (R&R and R&R2), Relapse Prevention Therapy (RPT) and Thinking for a Change (T4C).

The following section will describe about the target areas under each program and expected outcome of each. Aggression Replacement Training(ART) focuses on providing training to youngsters with prosocial skills to use in antisocial situations as well as skills to manage anger impulses that lead to aggressive and violent actions by social skills training(the behavioral component) teaches interpersonal skills to deal with anger-provoking events; anger control training (affective component) to imparting the training to reduce their affective impulses to behave with anger by increasing their self-control competencies and lastly (cognitive component) moral reasoning raise the young person's level of fairness, justice, and concern with the needs and rights of others. For the offenders who are convicted for committing the crime under the influence of drugs, substance abuse or poly substance abuse Strategies for Self-Improvement and Change (SSC) proves to working best with them. It includes three phases: challenge, commitment and ownership to change with aim to develop the self -awareness within the offenders. In the process of treatment, if the therapist finds that for some offenders there are chances of relapse, then those offenders are suggested for Relapse Prevention Therapy (RPT). The aim of RPT is to prevent and manage the relapse in case of addiction and drug abusers. Offenders are trained on self-management and self-control of their thoughts and behavior. This approach views addictive behaviors as acquired habits with "biological, psychological, and social determinants and consequences" (Marlatt, Parks, and Witkiewitz, 2002).

Moral Reconation Therapy(MRT) addresses on the moral reasoning training to the offenders. It is for the offenders with low levels of moral development, strong narcissism, low ego/identity strength, poor self-concept, low self-esteem, inability to delay gratification, relatively high defensiveness, and relatively strong resistance to change and treatment" (Little and Robinson, 1986). Reasoning and Rehabilitation (R&R and R&R2) program is meant for the offenders who suffer from cognition and social deficits. This primary focus of the program is on imparting the training that will make them suitable for the re-entry (rehabilitation of the offender) of the offenders into the community by addresses the associated issues. This program focuses on enhancing self-control, interpersonal problem solving, social perspectives, and prosocial attitudes (Wilson, Bouffard, and MacKenzie, 2005) where participants are taught to think before acting, to consider consequences of actions, and to conceptualize alternate patterns of behaviour. The last program of the CBT is Thinking for a Change (T4C) (Bush, Glick, and Taymans, 1997) which uses uses a combination of approaches to increase offenders' awareness of self and others. It integrates cognitive restructuring, social skills, and problem solving. The program begins by teaching offenders an introspective process for examining their ways of thinking and their feelings, beliefs, and attitudes. Problem solving becomes the central approach offenders learn that enables them to work through difficult situations without engaging in criminal behavior.

EFFECTIVENESS OF CBT

Unlike CBT in clinical settings, it is gaining popularity in forensic setting too. Many researches provide the evidence of CBT with offenders and reducing the rate of recidivism in treated offenders (Pearson et al., 2002). However there exists a mix response on the effectiveness as some studies suggest that CBT do not have any appreciable effect on recidivism (Martinson, 1974) whereas some studies supports the effectiveness in recidivism by CBT (Allen, MacKenzie, and Hickman, 2001; Andrews et al., 1990; Cullen and Gendreau, 1989)

Various studies on the effectiveness on CBT in Forensic setting provides the evidence that it works in managing and transforming the cognitive distortions into the adaptive behaviour by altering/ modifying the maladaptive ones. Handful of studies suggest that when children with sexual behaviour problems received cognitive behavioural interventions (CBT), they had roughly comparable less rates of future sex offenses (2%) compared to clinical comparison groups (3%) (Lindsey et. al , 2010). Another study by Pearson ,Lipton, Cleland and Yee (2002) also used a meta-analysis to study the effect of behavioural and cognitive behavioural programs on recidivism. They examined sixty nine studies from 1968 to 1998 that earlier used behavioural approaches or cognitive behavioural approaches to reduce recidivism, although they found that both types of interventions were more effective in reducing recidivism than their comparison groups ,cognitive behavioural approaches showed grater effects on recidivism than programs solely used behavioural approaches. Specifically, programs that focused on cognitive behavioural social skills development and cognitive skills programme were the most effective in reducing recidivism**.** Furthermore study byAndrews et. al. (1990) found programs that provided

appropriate correction interventions, such as cognitive behavioural treatment, were more effective in reducing recidivism than programme that did not follow the principles of effective interventions.

Despite of the CBT's effectiveness in the forensic setting and its sustainability within the correctional, observation home still there certain risk factors are also associated on re-entry of offenders in the community such as emotional, psychological, and family disruption in childhood and adolescence; involvement with an antisocial peer group as a youth and school problems or failure; alcohol and other drug use in childhood and adolescence. Apart from these there are some more factors that make them vulnerable to accept changes such as motivational level sustain the changes, role models and reinforces in the society and expression of disapproval stands in stark contrast to the levels of interest, concern, and warmth previously offered by the society and many more.

Indigenous researches on therapy shows that most of the researches are concentrated in clinical settings but there is very limited research on the applications of therapy in forensic setting i.e in observation home, prison setting and correctional setting in India. In the dearth of the available literature on therapeutic researches on forensic setting in India, it is very important for us to extend the services to above mentioned institutions which will help prisoners for recidivism and community re- entry.

LIMITATIONS

Implementing CBT in correctional settings also has its challenges. Although it addresses explicitly cognitions interfering behaviour, common correctional challenges to therapy such as lockdowns, group consequences for the behaviour of a few, and inmate on inmate pressure to conform to behaviours inconsistent with societal norms need to be specifically addressed by CBT providers. Another challenge is the necessity to provide CBT training for all staff members that interact with those receiving treatment. Low literacy rate accompanied by dyslexia or learning difficulties or mental illness among the offenders hinders the smooth process of treatment. Limitation to behavioural homework tasks also restricts them as these people have very less opportunity to do homework out of the session which prevents to go through the complete therapeutic process.

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Depression among T.B Patients

Dr. Santosh Kumar[1]*

ABSTRACT

The present study shows that the depression level of among the T.B patients the study finding shows that treatment for T.B is complicated and lengthy process but T.B can be curable by the medicine there is no significant difference between male and female T.B patients. There is no significant difference depression of T.B patient's.

Keywords: *T.B Patients, Medicine, WHO.*

The T.B. 1s called mycobacterium tuberculosis in active tuberculosis means that one can even unconsciously and unknowingly acquire the bacteria for tuberculosis within them but not even know about it because it is inactive. Whereas active tuberculosis is the start of the bacteria developing and the signs and symptoms begin to be visible. This is when tuberculosis is active within you and is a serious issue loading to even more serious results. Although the T.B. bacteria can infect any organ Kidney, Lymph bones Joints in the body. The disease commonly occurs in the lings.

Tuberculosis is one of India's Major public health problems. According to WHO estimates? India has the world's largest tuberculosis epidemic many research studies have shown the effects and concerns revolving around TDR-TB especially IN India, where social and economic positions are still in progression.

The Govt. of Karnataka and Govt. of India Jointly had put the effort to Erase of T.B in India. I every day In India 260 cases are coming newly at hospital what is Tuberculosis?

Tuberculosis (TB) is caused by a bacterium called Mycobacterium tuberculosis (MTB). It most commonly affects the lungs but can affect other areas of the body. The common symptoms of TB are coughing, fevers, night sweats and severe weight loss.

TB is highly infectious and is spread through the air if someone with the bacteria coughs, spits or sneezes. The disease is, however, curable and largely preventable.

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Most healthy people who contract the bacteria will never experience symptoms. However, people who are undernourished, whose immune system is compromised or who live in extreme poverty are more likely to become ill. TB is the second most deadly infectious disease worldwide. In 2013 worldwide 9 million people fell ill with TB and 1.5 million people died.

In Bangladesh, TB is a major public health problem, killing around 70,000 people a year. Bangladesh is the world's most densely populated country, allowing TB to spread quickly due to poor living conditions and a lack of knowledge about the disease.

TB can affect young people of working age. Poor health means they can no longer work and earn a living. The disease drives them further into poverty.

DOTS

Directly observed treatment, short-course (DOTS) is at the heart of the World Health Organization (WHO) Stop TB strategy. The basic five components are:

- Political commitment with increased and sustained financing
- Case detection through quality-assured bacteriology
- standardized treatment with supervision and patient support
- An effective drug supply and management system
- Monitoring and evaluation systems and impact measurement

Symptoms

Although your body may Harbor the bacteria that cause tuberculosis, your immune system usually can prevent you from becoming sick. For this reason, doctors make a distinction between:

Latent TB. In this condition, you have a TB infection, but the bacteria remain in your body in an inactive state and cause no symptoms. Latent TB, also called inactive TB or TB infection, isn't tuberculosis of the spine may give you back pain, and tuberculosis m your kidneys might cause blood in your urine.

When to see a doctor

See your doctor if you have a fever, unexplained weight loss, drenching night sweats or a persistent Gough. These are often signs of TB, but they can also result from other medical problems. Your doctor can perform tests to help determine the cause.

The Centers for Disease Control and Prevention recommends that people who have an increased risk of tuberculosis be screened for latent TB infection. This recommendation includes:

- People with HIV I AIDS
- IV drug users
- Those in contact with infected individuals
- Health care workers who treat people with a high risk of TB

Definition

Tuberculosis (TB) is a potentially serious infectious disease that mainly affects your lungs. The bacteria that cause tuberculosis are spread from one person to another through tiny droplets released into the air via coughs and sneezes.

Once rare in developed countries, tuberculosis infections began increasing in 1985, partly because of the emergence of HIV, the virus that causes AIDS. HIV weakens a person's immune system so it can't fight the TB germs. In the United States, because of stronger control programs, tuberculosis began to decrease again in 1993, but remains a concern. Many strains of tuberculosis resist the drugs most used to treat the disease. People with active tuberculosis must take several types of medications for many months to eradicate the infection and prevent development of antibiotic resistance.

Causes

Tuberculosis 1s caused by bacteria that spread from person to person through microscopic droplets released into the air. This can happen when someone with the untreated, active form of tuberculosis coughs, speaks, sneezes, spits, laughs or sings.

Although tuberculosis is contagious, it's not easy to catch. You're much more likely to get tuberculosis from someone you live with or work with than from a stranger. Most people with active TB who've had appropriate drug treatment for at least two weeks are no longer contagious.

CONCEPTUAL FRAlY. EWORK

HIV and TB

Since the 1980s, the number of cases of tuberculosis has increased dramatically because of the spread of HIV, the virus that causes AIDS. Infection with HIV suppresses the immune system, making it difficult for the body to control TB bacteria. As a result, people with HIV are many times more likely to get TB and to progress from latent to active disease than are people who aren't HIV positive.

Drug-resistant TB

Another reason tuberculosis remains a major killer is the increase in drug-resistant strains of the bacterium. Since the first antibiotics were used to fight tuberculosis 60 years ago, some TB germs have developed the ability to survive, and that ability gets passed on to their descendants.

Drug-resistant strains of tuberculosis emerge when an antibiotic fails to kill all of the bacteria it targets. The surviving bacteria become resistant to that particular drug and frequently other antibiotics as well. Some TB bacteria have developed resistance to the most commonly used treatments, such as ionized and revamping.

Where you work or live

- Health care work. Regular contact with people who are ill increases your chances of exposure to TB bacteria. Wearing a mask and frequent hand-washing greatly reduce your risk.
- Living or working in a residential care facility. People who live or work in prisons, immigration centers or nursing homes are all at a higher risk of tuberculosis. That's because the risk of the disease is higher anywhere there is overcrowding and poor ventilation.
- Living in a refugee camp or shelter. Weakened by poor nutrition and ill health and living in crowded, unsanitary conditions, refugees are at especially high risk of tuberculosis infection.

Complications

Without treatment, tuberculosis can be fatal. Untreated active disease typically affects your lungs, but it can spread to other parts of the body through your bloodstream. Examples of tuberculosis complications include:

- Spinal pain. Back pain and stiffness are common complications of tuberculosis.
- Joint damage. Tuberculosis arthritis usually affects the hips and knees.

Blood tests

Blood tests may be used to confirm or rule out latent or active tuberculosis. These tests use sophisticated technology to measure your immune system's reaction to TB bacteria. Quanti FERON-TB Gold in-Tube test and T-Spot. TB test are two examples of TB blood tests.

These tests require only one office visit. A blood test may be useful if you're at high risk of TB infection, but have a negative response to the skin test, or if you've recently received the BCG vaccine.

Imaging tests

If you've had a positive skin test, your doctor is likely to order a chest X-ray or a CT scan. This may show white spots in your lungs where your immune system has walled off TB bacteria, or it may reveal changes in your lungs caused by active tuberculosis. CT scans provide more-detailed images than do X-rays.

Sputum tests

If your chest X-ray shows signs of tuberculosis, your doctor may take samples of your sputum - the mucus that comes up when you cough. The samples are tested for TB bacteria.

Most common TB drugs

If you have latent tuberculosis, you may need to take just one type of TB drug. Active tuberculosis, particularly if it's a drug-resistant strain, will require several drugs at once. The most common medications used to treat tuberculosis include:

- Isoniazid
- Rifampin (Rifadin, Rimactane)

- Ethambutol (Myambutol)
- Pyrazinamide

If you have drug-resistant TB, a combination of antibiotics called f luoroquinolones and inject able medications, such as amikacin, kanamycin or capreomycin, are generally used for 20 to 30 months. Some types of TB are developing resistance to these medications as well.

A number of new drugs are being looked at as add-on therapy to the current drug-resistant combination treatment including:

- Bedaquiline
- Delamanid
- PA-824
- Linezolid
- Sutezolid

Prevention

If you test positive for latent TB infection, your doctor may advise you to take medications to reduce your risk of developing active tuberculosis. The only type of tuberculosis that is contagious is the active variety, when it affects the lungs. So if you can prevent your latent tuberculosis from becoming active, you won't transmit tuberculosis to anyone else.

Protect your family and friends

If you have active TB, keep your germs to yourself. It generally takes a few weeks of treatment with TB medications before you're not contagious anymore. Follow these tips to help keep your friends and family from getting sick:

- Stay home. Don't go to work or school or sleep in a room with other people during the first few weeks of treatment for active tuberculosis.
- Ventilate the room. Tuberculosis germs spread more easily in small closed spaces where air doesn't move. If it's not too cold outdoors, open the windows and use a fan to blow indoor air outside. Symptoms

The bacterium that causes TB 1s called Mycobacterium tuberculosis. Inactive tuberculosis means that one can even unconsciously and unknowingly acquire the bacteria for tuberculosis within them but not even know about it because it is inactive. Whereas, active tuberculosis is the start of the bacteria developing, and the signs and symptoms begin to be visible. This is when tuberculosis is active within you, and is a serious issue leading to even more serious results. Although the TB bacteria can infect any organ (e.g., kidney, lymph nodes, bones, joints) in the body, the disease commonly occurs in the lungs.

Common symptoms include:

- Coughing that lasts longer than 2 weeks with green, yellow, or bloody sputum
- Weight loss
- Fatigue
- Fever
- Night sweats
- Chills
- Chest pain
- Shortness of breath
- Loss of appetite

Dispersed throughout the country. Pollution causes many effect in the air the people breathe there. and since TB can be gained through the chances of TB remain high and in a consistent movement going uphill: for India.

Treatment

India has a large burden of the world's TB, one that this developing country can ill afford, with an estimated economic loss of US $43 billion and 100 million lost annually directly due to this disease. Treatment in India is on the rise just as the disease itself is on the rise. To prevent spreading TB, it's important to get treatment quickly and to follow it through to completion by your doctor. This can stop transmission of the bacteria and the appearance of antibiotic-resistant strains. It is a knowingly fact that bacterial infections require antibiotics for treatment and prevention, thus, commonly you will see that patients diagnosed with tuberculosis have certain pills and antibiotics carried around with them. The antibiotics most commonly used include isoniazid, rifampin, pyrazinamide, and ethambutol. It is crucial to take your medication as instructed by your doctor, and for the full course of the treatment (months or years). This helps to ward off types of TB bacteria that are antibiotic-resistant, which take longer and are more difficult to treat.

REVIEW OF LITERATURES

The concept of Depression Among T. Patients has been studied in myriad situations of individuals and its health enhancing qualities and the feeling of being cared for loved and accept cannot be under estimated, the presence of aid and support from significant others in the form Depression T.B. Patients appropriate representation of psychological assets or resources. Therefore is necessary to explain to T.B patients.

Donald and ware (1984) concluded that subjective rating of being cared for and loved and wanted by others are substantially related both conceptually and empirically to mental health. A Depression or T.B Patients system may increase unreliability to mental illness.

Smith and Hobbs (1996) and Hibbard (1985) observed that mental illness is not the private misery of any individual but in the individual life involving family, job, friendship and religious affiliations. "The relationship between Depression and status of health indicated the having more socialites being more trust full of others and perceiving more control are all related to having butter health.

METHODOLOGY

1) Statement of problem :

To study the psychological "Depression Among T.B Patients.

2) Variables:-

a) Independent variable

- Gender
- Rural

b) Dependent variables

- Depression among T.B. Patients

3) Objectives:

a) To know the symptoms of psychological Depression among T.B patients.
b) To know the difference in the level of psychological Depression among T .B patients of male and female.
c) To know the difference in the level of Depression IN rural Patient's
d) To know the difference in the level of Depression male and female T.B patients.
e) To know the difference In the level of Depression In TB patients

4) Hypothesis

a) There 1s significant relation between depression among T.B patients.
b) There is significant difference in depression of male and female T.B patients.
c) There is significant difference m depression among rural TB Patients.
d) There is significant difference in depression male and female of TB patients.
e) There is significant difference in depression T.B patients rural.

5) Sample Design

Area	Male	Female	Total
Rural	25	25	50
Total	25	25	50

The total sample of present study is 50 patient. The Rural Female 25 Patients and 24 male patients and the sample were selected in Jewargi Govt. hospital.

DISCUSSION

Table showing mean SD and T- Value of Depression T.B patrician's

Area	Male	Female	Total
Rural	25	25	50
Total	25	25	50

The table shows result of depression among male and female the mean score of male is 107 .96 and standard Deviation (S.D) is 21.81 that of female mean score is 120.68 and SD is 43 .10 there is significant deference mean and SD value of male and female patients.

When t-test is applied to know the significant Difference It's found the obtained T-value of T= 1.31 it is not significant difference in male and female T.B depression patients.

CONCLUSION

- Treatment for T.B is a complicated and lengthy process.

- T.B. patients' can cure by medicine
  - There is no significant difference Between male and female T.B patients
- Now T.B controlling by Awareness
  - There is no significant difference Depression of T.B patient's

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The Easterlin Paradox- The Haves, The Have-Nots and The Happiness

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ABSTRACT

The past research claims that poverty has a broad negative impact on happiness of individuals. The money doesn't make you happier, but lack of money makes you sadder. It has been observed that the poor are more likely than the affluent to be exposed to stressful life events, such as unemployment, illness and victimization etc. Poverty is not only economic limitations of people, it also encompasses the dissatisfaction of psychological and psychosocial needs, which if met, would elevate well-being of individuals. This paper uses inductive approach to understand the economics of happiness and a feeling of powerlessness in poverty-stricken population and attempts to uncover how poverty leads to a lack of happiness.

Keywords: *Happiness, Have-Nots, Poverty, Well Being.*

Happiness is an end that all of us seek through various means. Many scholars have argued that the happiness is the ultimate goal of human action. For instance, Aristotle, in his book, *Ethics*, identified happiness as the chief and final good. The concept of happiness has been a subject of interest to social science researchers lately. Everybody in life desires happiness and this could come as a result of many factors including some socio-economic factors. Rich and poor alike strive for happiness. Happiness studies reveal that the individuals' increased income does not automatically lead to greater happiness. But being poor certainly decreases one's chance of being happy. The term happiness is sometimes used interchangeably with the term subjective well-being in literature. The concept of subjective well-being or happiness comprises of how people evaluate their lives, short term as well as long term. These evaluations include their emotional reactions to events, their moods, and also the judgments about their life satisfaction, marital relationship satisfaction and job-satisfaction etc. (Diener et al. 1993). There are two distinct perspectives that revolve around two distinct philosophies while attempting to define happiness and well being. The first of these is labelled as hedonism and asserts that well-being consists of pleasure or happiness. The second view asserts that well-being consists of more than just

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happiness. It lies instead in the actualization of human potentials This latter view has been termed as eudaimonism (Waterman 1993). It consists of the belief that well-being means fulfilling or realizing one's daemon or true nature. The Hedonism view states that the goal of life is to experience the maximum amount of pleasure. The Eudaimonism view on the contrary argues that true happiness is found in the expression of virtue—that is, in doing what is worth doing. Eudaimonic theory maintains that not all desires and not all their outcomes that an individual values would yield well-being when achieved. Some outcomes might not be good for people and might not promote wellness even though they are pleasurable.

Poverty is defined as a state characterized by ill-being and a lack of resources, inferior to wealth which is regarded as a state of abundance and well-being. The World Health Organization has described poverty as the greatest cause of suffering on earth. In *Bridging the Gaps*, the World Health Organization (1995) states, 'The world's most ruthless killer and the greatest cause of suffering on earth is extreme poverty.' This statement reveals how important poverty as a variable is in adversely affecting the health. Poverty is a multidimensional phenomenon, consisting of an inability to satisfy basic needs, lack of control over resources (powerlessness), poor health and a lack of education in addition to lack of many basic amenities of life. Poverty can have alienating and distressing effects on the individuals and of particular concern are the direct and indirect effects of poverty on are the emotional, behavioural and psychological problems in the affected individuals. Poverty has wide ranging negative consequences for quality of life**.** The poor are more likely than the well off to be exposed to stressful life events like unemployment and illness. Happiness varies directly with one's own income and inversely with the incomes of others. Karl Marx put it this way: 'A house may be large or small; as long as the surrounding houses are equally small it satisfies all social demands for a dwelling. But if a palace rises beside the little house, the little house shrinks into a hut' (as quoted in Lipset, 1960, p. 63). The defining experiences of the poor involve limited choices, an inability to make themselves heard, less or no control over what happens to them (powerlessness). Powerlessness is born from multiple, interlocking social and economic disadvantages, which, while operating together in combination with each other, make it difficult for the poor to escape poverty.

REVIEW OF LITERATURE

Researchers have studied whether high income individuals are happier and reported a correlation between higher income and greater happiness (Clark, 2008). The poor have to live with chronic strains such as economic hardship, frustrated aspirations and job-dissatisfaction (Kessler 1979; Liem and Liem 1978; Ross and Huber 1985; Williams 1990). These experiences are not only upsetting but they are also likely to lower individual's self-esteem and diminish their sense of control over life leading to a feeling of powerlessness (Pearlin et al., 1981; Mirowsky and Ross 1989). The poor also appear to have relatively fewer social resources to draw on, smaller social networks, less organizational involvement, and less frequent contact with friends and family as compared to the people with high income (Cochran et al., 1990; d'Abbs, 1982; Fischer, 1982; House et al., 1988). This is so may be because economically deprived people lack the economic

resources to maintain extended social networks. Low socioeconomic status (SES) people find their social relationships less useful in coping with daily stressful life events than high SES individuals (House et al., 1988; Liem and Liem, 1978). Poverty is also linked with lower social support from immediate family members: poor marital relations, high risk of divorce, and general dissatisfaction with family life (Conger et al.,1990; Lewis and Spanier, 1979; Voydanoff and Donnelly, 1988).

As research reveals that poverty is associated with stress, chronic strains, low social support, and difficult marital relationships, it is not surprising that the poor also have a comparatively low level of psychological well-being. Dohrenwend and Dohrenwend (1974) and Haring et al. (1984) indicate that low SES correlates with with high rates of depression, mental illness, and low psychological well-being. Deprivation and abject poverty are found to be detrimental to happiness. The behavioral economics literature reveals that people value losses disproportionately to gains (Kahneman et al.,1999). Recent studies conducted at Michigan State University and University of British Columbia revealed that higher income is associated with experiencing less daily sadness, but has no bearing on daily happiness (Kushlev et al., 2015).

Some researchers obtained cross-section data on multiple countries. They based their results on comparisons. The results obtained indicated a much lower correlation between income and subjective wellbeing within a country as compared to between countries (Diener et al., 1999). There are researches that provide evidence that countries with higher income have higher average levels of well-being (Diener et al., 1995) revealing that individuals in richer countries, as well as richer individuals in one country, are slightly happier. The idea that happiness is caused by wealth is a fundamental belief in capitalistic societies (Martial,2006). Myriads of studies confirm that in poorer countries, income does act as a predictor of well being (Diener, 2009).

Other studies by some other researchers such as Achor (2010), Diener (2009), Maital (2006), and King (2006), are a part of the new research that supports the idea that happiness causes greater wealth. It is also noticed that one single factor may not be the one influencing the happiness in its entirety (Ebrahim et al. 2013; Diener and Selicman 2006; Møller and Radloff 2010; Tella and MacCulloch 2008; Van Boven, 2005; Buchanan and Csikszentmihalyi 1991; Lynn and Steel 2006). Many researchers have tried to understand the individual relationships between various demographic, sociological, psychological, and behavioral characteristics and self-assessments of happiness (Borrero et al. 2013). Different scholars have documented that income, education, marriage, health, employment, social participation, and positive feelings, all are directly correlated with happiness (Borrero et al. 2013; Clark, 2003; Frey and Stutzer, 2002; Di Tella et al., 1999; Ravallion and Lokshin 2001; Shin and Johnson 1978; Blanchflower and Oswald 2000; Easterlin 1974, 1995, 2001).

The studies also reveal that absolute and relative incomes are not the only economic determinants of happiness. Unemployment is also found to reduce happiness in the individuals

(Clark and Oswald, 1994; Winkelmann and Winkelmann, 1998). Another index of economic insecurity is inflation. The countries with higher inflation display lower level of happiness (Di Tella et al., 2001). Furthermore, subjective well-being is influenced by many factors that are non-economic, such as age, sex, marital status, health status, education, religiosity etc. (Helliwell, 2002).

THE EASTERLIN PARADOX

Richard Easterlin was the first modern economist to examine the relationship between individual's assessment of happiness and his income (Hernandez-Murillo, 2010). Surveying 19 countries, Easterlin found out that within a country people with higher income reported being happier (also observed by Oswald, 1997; Diener et al., 2003). But the studies conducted across countries and over time have found very little, if any, relationship between increases in per capita income and average happiness levels of people. On average, wealthier countries (as a group) are found to be happier than poor ones (as a group). In these studies happiness appears to rise with income up to a point, but not beyond it. Yet even among the poorer and less happier countries, there is not a clear relationship between average income and average happiness levels, which suggests that many other factors might be at play. Easterlin's findings are a major breakthrough in happiness economics. Happiness Economics is an approach combining the techniques used by economists with those used by psychologists in assessing welfare. The surveys of the reported well-being of individuals across countries and continents are collected. The economics of happiness does not attempt to replace income-based assessment of welfare, instead to complement it with broader measures of well-being of individuals.

CONCLUSION

It can be concluded that richer individuals in the same country are only (if at all) slightly happier than their less advantaged poor co-citizens. The economic growth in many developed countries has not led to happier individuals. On the other hand, a high income allows people in modern societies to indulge in luxurious leisure activities, make purchase of the latest technological goods, and buy expensive cars and houses. The majority of individuals express explicit interest in obtaining a higher income level, signaling that leading a luxurious life is the ultimate goal for them. Those who are below poverty line or slightly above it, are grappling with the deprivation. The question arises, how can we address the relationship between poverty, powerlessness and happiness? To do this, we must work along with the communities to analyze and address the root causes of the poverty, deprivation and injustice which define the lives of the deprived lot of society. All government policies likely to have a direct or indirect effect on poor people should be evaluated in terms of their impact on these people. These policies should be formulated in such a way that by favouring those who are less well-off, such inequalities should be reduced from the society. The above findings challenge all those committed to working for poverty reduction. The realities of poor people's lives must inform policymaking at macro as well as micro levels.

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Impact of Yogic Practises on Risk Taking Behavior of Attension Deficit Hyperactivity Disorder Children

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ABSTRACT

Attention deficit hyperactivity disorder is one of the most common childhood disorders and can continue through adolescence and adulthood. The purpose of this research was to explore the advantages of yogic practices on risk taking behavior of ADHD. Present study has pre and post experimental design which was conducted on 30 pre diagnosed ADHD School going children with the age group of 8 to 12years selected on random basis. The sample was divided into two control and experimental groups. The Balloon analog risk task (BART) was used for assessment of risk taking behavior of ADHD. The experimental group was given 10 specific yogic practice sessions whereas the control group was given no intervention. Pre and post results indicated that there was no change in the control group in reference to risk taking behavior whereas there was improved in the risk taking behavior of children with ADHD in the experimental group. The positive correlation was found between Yogic practices and risk taking behavior improvement.

Keywords: *Attention Deficit Hyperactivity Disorder, Risk Taking Behavior, Inattention, Hyperactivity.*

Attention deficit hyperactivity disorder (ADHD) is one of the most common childhood disorders and can continue through adolescence and adulthood. ADHD is a neurobehavioral developmental disorder among school-age children, affecting about 8-12% of children world-wide. (Faraone SV et al 2003) An epidemiological study by Srinath et al (2005), showed the prevalence of ADHD to be 1.6% among children less than 16 years, posing costly demands on medical, psychological and societal resources in India. The child with ADHD will have difficulty in concentrating on a task, at home and school. This, predictably, leads to considerable distress among the care givers. (Musa RS et al 2007)

There is a lot of intervention techniques are available for ADHD like medication, yoga, homeopathy, cognitive behavior therapy (CBT), massage therapy, nutrition therapy, naturopathy and hypnosis. The Yoga and Medication are taken for discussion & review purpose. Yoga is an

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ancient technique of India that makes healthy body & mind both, and Medication is the most common technique all around the world for any physical and mental problem.

Yoga and ADHD

There are relatively two studies on meditation techniques applied to childhood AD/HD and the one study indicating improvement in impulsivity and improved performance on an attentional measure (Kratter J.1983) and another indicating improved classroom behavior. (Moretti-Altuna G.1987)

Jensen PS & Kenny DT (2004) yoga considered as a complementary treatment to medication in reducing the behavioral and attention deficit symptoms.

Harrison,et al (2004) studied effect of Sahaja Yoga Meditation (SYM) on improving stability of attention and concentration, motor activity, problems of inhibition, easily frustrated mood, poor self-esteem and difficulties at school of children with ADHD.

Peck, H. et al (2005) examine the effectiveness of yoga on improving attention in elementary school children with attention problems.

This study of mindfulness meditation in adults conducted by Monastra V. (2008) has suggested that it may have beneficial effects on cognitive activities such as shifting set and possibly, in improving working memory

A review by Krisanaprakornkit T. et al (2010) to assess the effectiveness of meditation therapies as a treatment for ADHD. Two studies used mantra meditation while the other two used yoga compared with drugs, relaxation training, non-specific exercises and standard treatment control. Design limitations caused high risk of bias across the studies.

A study conducted by V.R. Hariprasad et al (2013). Children with ADHD and co-operative for yoga were included. There was a significant improvement seen in the ADHD symptoms at the time of discharge.

Meera Balasubramaniam et al (2013) examined the evidence for efficacy of yoga in the treatment of selected major psychiatric disorders. Evidence supported a potential acute benefit for yoga exists in ADHD.

Purpose of the research

There are many researches on therapeutic interventions for ADHD but there are no as such researches on single alternative therapy like Yoga, meditation or combined models, thus this research work propose to study the comparison of single & combined model of intervention for treatment of ADHD. Thus the aims and objectives are as follows:-

Aims & Objectives

- To study the effect of individual intervention (yoga and meditation) on risk taking behavior of ADHD suffering children.

Hypothesis

1) There will be no significant difference between pre and post risk taking behavior score in control group.

2) There will be significant difference between pre and post risk taking behavior score in experimental (yoga intervention) group.

METHODOLOGY

Study Design

The study has Pre-and-Post research design. Nature wise it is a pilot study. Two groups formulated respectively - 1 control group and 1 experimental group. Intervention time of therapy is 10 days.

Intervention

Specific yoga training conducted in 10 sessions of 45 minutes and each session contents 30 min asana and 15 min trataka practice. Asana sequence as followed:

1) Spot jumping and clapping
2) Vajrasana
3) Supta vajrasana
4) Shashankasana
5) Pashchimottanasan
6) Chakrasana
7) Tadasana
8) trataka

Sample

- Class: Pre diagnosed ADHD primary school children
- Age group: 8-to-12 year's students
- Gender: Male and female
- Socio economic status: Middle class
- Demography: Urban

Sample size

1) Total sample size -30
2) Group 1- 15
3) Group 2- 15

Groups:-

1) Group 1- Control group
2) Group 2- Experimental group

Tool:- Balloon analogue risk task (BART) online version

Method and Procedure

1) 20 pre diagnosed school going ADHD children selected.
2) The sample was divided randomly in to two groups of N/2 children.
3) Group 1st is control group.
4) Group 2nd is experimental group (Intervention with Yoga).
5) Pre –risk taking behavior scoring of every group was taken with the help of BART at the beginning of procedure.
6) Excluding 1st control group, other experimental groups was passed with yoga interventions for 10 sessions.
7) After 10 sessions Post- risk taking behavior scoring of every group was taken to assess the reduction in impulsivity symptoms.

STATISTICAL ANALYSIS

T-Test

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Control group	pre	187.67	15	15.337	3.960
	post	191.00	15	13.120	3.388
Experimental group	pre	188.67	15	14.936	3.857
	post	336.20	15	15.086	3.895

Paired Samples Correlations				
		N	**Correlation**	**Sig.**
Pair 1	Cont.post & Cont. pre	15	.616	.015
Pair 2	Exp. post & Exp. pre	15	-.086	.761

Paired Samples Test									
		Paired Differences							
					95% Confidence Interval of the Difference				
		Mean	**Std. Deviation**	**Std. Error Mean**	**Lower**	**Upper**	**t**	**df**	**Sig. (2-tailed)**
Pair1	Cont. post – Cont pre	3.333	12.630	3.261	-3.661	10.328	1.022	14	.324
Pair2	Exp. post – Exp. pre	147.533	22.123	5.712	135.282	159.784	25.829	14	.000

DISCUSSION

There is no significant difference found between pre and post risk taking behavior score in control group thus the first hypothesis proved. And There is significant difference found on the level of .05% between pre and post risk taking behavior score in experimental (yoga intervention) group, when degree of freedom is 14. Then second hypothesis also proved. Results shows yoga intervention reduces risk taking behavior. Pre and post results indicated that there was no change in the control group in reference to risk taking behavior whereas there was improved in the risk taking behavior of children with ADHD in the experimental group. The positive correlation was found between Yogic practices and risk taking behavior improvement.

CONCLUSION

Pre and post results indicated that there was no change in the control group in reference to risk taking behavior whereas there was improved in the impulsivity of children with ADHD in the experimental group. The positive correlation was found between Yogic practices and risk taking behavior improvement.

Ethical consideration

- Written informed consent was obtained from the parents of all students.
- Confidentiality of the obtained data was strictly maintained.
- Participants were informed about absence of any tangible benefits for participating in the study.

There were certain limitations in the study:

1. The sample size was restricted to few children. Hence in future, a similar study needs to be conducted on a larger section of the ADHD children.
2. For avoiding gender differences, both male and female included in the sample.
3. Time limitation is also their.

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Self-Concept among Adolescents of Mixed Sex and Single Sex Education Schools

Shreshtha Dhar[1]*, Saranya Banerjee[1], Anindita Mukherjee[1], Atanu Kumar Dogra[2]

ABSTRACT

School plays a vital role in biopsychosocial development among students. One of the common debates of modern educational system is whether mixed sex education or single-sex education is beneficial for the bio psychosocial development of adolescents. However previous research findings have not provided sufficient evidence to resolve the controversies, this study aimed at clarifying the question of 'which nature of schooling is effective for multi-dimensional self concept?' To resolve the controversy, self concept of boys and girls of four mixed sex schools and four single sex education schools was assessed with the help of Multidimensional self-concept scale (MSCS)(Bruce and Bracken, 1992) . Data were statistically analyzed with help of t test. As per result, competence and academic dimensions of self were found to be higher in students from single sex schooling but social dimension of self was elevated in students from mixed sex schooling for both sexes. Girls were found to have scored significantly higher than boys on social dimension of self for both types of schooling.

Keywords: *Self-Concept, Mixed Sex And Single Sex School.*

Schooling is an essential part of everyone's life. Besides family, school also helps people to know how to move in society, how to behave with others and how to progress in life. Especially, it is an essential place where children have interactions with their peers, form companionship, and participate in social groups with other children. Especially, as children grow up from infancy to adolescence, peers and school gradually become more significant in their lives. But a question arises in parents that which type of schooling (same sex verses mixed sex) is beneficial for their child. Some parents feel and prefer traditional unisex education due to sex disparities in psychosocial development, but others think that unisex schooling is not an effective process for the development of an androgynous personality of the individual. So, they prefer the trend of mixed sex education.

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So, social scientists always face a controversy about the effectiveness of mixed sex education and unisex education on bio-psychosocial development of children. In their developmental process, one of the important issues is self development. Self-concept is used to refer to how someone thinks about, evaluates or perceives themselves. According to Bracken (1992, p.10),self-concept is 'a multidimensional and context-dependent learned behavioural pattern that reflects an individual's evaluation of past behaviours and experiences, influences an individual's current behaviours, and predicts an individual's future behaviours. 'These different dimensions are unique and distinct. During the span of development, these different dimensions of self concept of every individual develop in different directions according to their exposure. From student's perspective, although some studies found that self-concept for girls were more obtained in female-only environments (e.g., Cipriani-Sklar, 1996; Riordan, 1990), girls also get greater self-confidence in cognitive domains in single-sex classes (Cairns, 1990) and mathematics (Mallam, 1993) and persistence in mathematics (Rowe, 1988), but Wing-man Winnie (1994) found that mixed sex education is better than single-sex education for the psychosocial development of adolescents, because single-sex schools segregate its students from peers of the opposite sex.

Hence, over the past five decades of researches, there has been ongoing debate about the advantages of mixed sex educational and single-sex education for children's bio-psycho-social and educational development; there is no conclusive finding from previous studies to resolve the controversy. So the objectives of the research are: a)to compare between different dimensions of Self-concept of the students studying in a mixed sex education school and single sex education school separately. b) to compare between different dimensions of Self-concept of the boys and girls studying in a mixed sex education school and Single sex education school separately.

METHOD:

Participant*:*

The total numbers of participants in the study were six hundred students studying in the secondary schools in Kolkata. From those entire participants, 150 females & 150 males were purposively selected from four mixed sex education schools and 150 females and150 males were purposively selected from four single sex education school son the basis of following inclusion criteria were:1) Age of the subjects: Between 13 to 15 years. 2) Locality: Residing in Kolkata for at least 5 years.3) Religion: Adolescents belonging to Hinduism were included in the sample.4) Educational Status: Students of 9th and 10th standard.5) Educational institution: Students of recognized private single sex and mixed sex education English medium schools from standard one.6) Parental Income: Rs 40,000 to Rs 50,000 per capita7) No. of Sibling: None. 8) None of the students were transfer students. 9) All the participants attended mixed sex coaching centres for 4-6 hours every week.

The exclusion criteria were:

1) History of any acute physical illness, physical handicaps or chronic illness having residual effect. 2) History of any past psychiatric illness.3) Any present illness or history of any mental illness, having residual effect. 4) Students not willing to answer all the items of the questionnaires. 5) Students having access to social networking sites.

Instrument:

The data for this study was collected from the following sources:

a) Personal information schedule includes socio-demographical details and psychological profiles.
b) Multidimensional self-concept scale (Bruce and Bracken, 1992):The MSCS is based on a hierarchical model of self concept. This model presumes that the multiple dimensions that constitute self concept are moderately intercorrelated. This includes include social, competence, affect, physical, academic and family (e.g., Bannister & Agnew, 1977).Bracken (1992) reported high internal reliability estimates, ranging from .87 on the Competence subscale to .98 on the Total scale. Concurrent validity results have shown full scale correlations between the MSCS and the Coppersmith Self-Esteem Inventory, the Piers-Harris Children's Self-Concept Scale and the Self Description Questionnaire II ranging from .69 to .83.

Procedure of study:

The selected schools were visited and the Principals or Vice Principals of the respective schools were approached for their approval and cooperation to collect data from their students. The subjects were selected on the basis of the inclusion/exclusion criteria after getting their consent. After obtaining permission and ensured cooperation, the students were approached. The nature of the research was explained to them. They were asked to volunteer for the study and it was assured that their responses will be strictly confidential and it would not be used in any other way apart from using it in the present study. They were asked to fill up the Personal Information Schedule. Then MSCS was given to the students and asked to fill them up. Clear instructions were given before administration of each questionnaire and its response categories. Ambiguities arising during and after administration of the questionnaires were clarified by the researcher.

Examination, Scoring and Treatment of Data:

The statistical treatments of the scores were done by using SPSS version 21.0. Keeping in view the objectives as well as design of the study, mean, standard deviation and inferential statistics were done to calculate all data. Since homogeneity of error variances exist among group (measured in terms of levene test), independent t tests were done to measure significant difference between means.

RESULTS:

In comparison between single sex and coeducation , significant differences were observed in competence [t (df=298) = 9.85 (p<.01) for boys and t (df=298) = 10.69 (p<.01) for girls] and academic dimensions [t (df=298) = 12.95 (p<.01) for boys and t (df=298)= 10.60(p<.01) for girls] among all dimensions of self concept and it was also found that higher scores are observed in students from single sex schooling than mixed sex schooling. In other side, social dimension of self [t (df=298) = 6.57 (p<.01) for boys and t (df=298) = 8.18 (p<.01)] was elevated in students from mixed sex schooling for both sexes than students from single sex schooling. In comparison between boys and girls, Girls were found to have scored significantly higher than boys on the social dimension of self-concept for both types of schooling [t (df=298) = 13.07 (p<.01) for coeducation and t (df=298)= 10.30 (p<.01) for single sex school].

DISCUSSION:

Self concept is a social cognitive multidimensional construct (Bergman, 2004; Harter, 2006) and among different socio-cultural mirrors like family, schooling, peer group, school plays as a chief determinant in development of self. Especially, though, adolescent spends more time in school than any other place outside of their home, interaction with peers, teachers, curriculum and co-curriculum influence their self development. In the present study, role of nature of schooling on social, academic and competent dimensions of self concept were observed.

Social self concept is conceptualized as the self-evaluation which is derived from their social interactions with significant others. It depends upon their conformity to the expectation of their peer groups, their role playing and how they are judged by others. As a whole, the environment and its feedback have a role in the development of the social self concept. In comparison between two types of schooling, adequate Social self concept is more developed in children of mixed sex schooling than in single sex schooling. Since students from both the types of schools were exposed to mixed sex coaching centers for 4-6 hours every week, it might be inferred that the difference in the social self concept of the students is due to the differences in the nature of the schooling. The difference might have occurred because students from the mixed sex schools get more opportunity to interact with peer groups irrespective of their sexes. It facilitates to learn how to play different roles and reach the expectation of the social group. It might enhance their communication skills, experiences and knowledge of gender equality which is helpful for perspective taking of opposite sex. Hence, these traits might be generalized in their flexible, friendly attitude toward opposite sex in real social life and it is also reciprocated from society also. It helps to develop better social self concept. So, their social self was better than students from single sex schooling. Findings of few British literatures (Dale, 1969, 1971, 1974; Schmuck, 2005; Smyth, 2010) are consistent with the present study that co-educational schooling was healthier for development of both sexes.

In case of competence and academic domains of self, the picture is opposite. Competence self refers to the self evaluation toward one's abilities and academic self is conceptualized as self

appraisal regarding own academic success. Although own abilities play a role, children have a tendency to evaluate own self based on the performance of others and how others (friends and teachers) evaluate them on their academic performance. Similarly, competence or ability self depends upon perception towards own capability and limitation of a child. Students from single sex schooling express their self competence and academic self better than students of mixed sex school. This difference might be occurred due to a few reasons:

Firstly, it might have occurred due to the notion of gender stereotypes regarding the capabilities of specific few subjects 'understanding. So, in case of mixed schooling, when they are forced to express their performance in gender atypical subjects, they lose their confidence which is reflected in their self concept and self efficacy. A substantial amount of literatures (Halpern et al,2007; Mael,1998;Marsh &Yeung,1998) suggest that boys have higher academic self concepts in 'masculine' subject areas based on visuospatial skills but girls may be expected to have higher verbal abilities than boys.

On another side, in the single sex learning environment, the effects of gender stereotypes have been shown to be lesser and students of both sexes are more likely to take subjects and participants in activities outside traditional sex roles (Billger, 2009; Dalley-Trim,2007). Studies by Cater,2005;Malacova,2007; Eisenkopf et al.,2012 have found that females frequently expressed more confidence and achieved better in the single sex schooling environment.

Secondly, it might have occurred because boys contribute more to classroom interaction in mixed sex schooling (Francis, 2004) and boys tend to be more disruptive in classroom interaction (Francis 2000) which adversely affect girls academic engagement and achievement and finally, on self .

From the perspective of sex, social dimension of self is significantly higher in girls rather than boys irrespective of schooling. It might be because of our cultural learning. In our society, girls are more forced to learn social rules, moral values from adolescence than boys. These are reflected through healthier social interaction and constitute the social self concept. This findings are consistent with Rosenberg and Simmons (2000) also stated that girls in adolescence are more conscious and more concerned with promoting interpersonal harmony.

CONCLUSION:

Overall, the present study reveals a controversial picture about the efficacy of schooling on development of self concept among adolescent. Hence competence and academic dimensions of self was found to be higher in students from single sex schooling and social dimension of self was elevated in students from mixed sex schooling for both sexes. Therefore one can attempt to set up a school where students of both sexes are free to interact with each other in their leisure time but they are given the opportunity to acquire the knowledge in separate classrooms. This setup might be more effective than present schooling style in Bengali culture.

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Table 1: Showing Means And Standard Deviations For Self-Concept For Single Sex Education School And Co- Education School Children.

Self concept	**Male**				**Female**			
	Co- education		Single sex education		Co- education		Single sex education	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Social	71.8	6.93	66.8	6.27	82.78	7.63	75.66	8.06
Competence	64.74	6.77	72.62	7.29	63.36	7.28	72.34	7.57
Affect	74.26	7.21	72.7	7.83	73.58	8.09	75.14	14.48
Academic	62.86	8.13	73.74	6.39	64.96	11.05	75.64	8.49
Family	75.76	10.04	78.08	10.99	77.12	9.20	76.4	8.56
Physical	75.74	10.15	73.41	8.75	73.78	9.37	71.6	10.56

Table 2 : Showing t values between different dimensions of self concept of boys and girls of both types of schools and t values between different dimensions of self concept of single sex and coeducation students of boys and girls separately.

Self concept	**Between co –education & single sex education for boys &girls**		**Between boys &girls for co-education single sex education**	
Social	6.57**	8.18**	13.07**	10.30**
Competence	9.85**	10.69**	1.725	0.32
Affect	1.75	0.75	0.92	1.67
Academic	12.95**	10.60**	1.36	1.66
Family	1.88	1.68	1.13	1.48
Physical	1.63	1.59	1.73	1.83

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Self-Esteem and Coping among Children with Borderline Intelligence and Average Intelligence

Dr. Hosamani Marilingappa[1]*

ABSTRACT

The aim of the study was to understand self esteem and coping among children with borderline intelligence and average intelligence. The sample consists of two groups, 30 children of borderline intelligence and 30 children of average intelligence in the age ranged of 8 to12 years and studying in 4th to 6th. Individuals with any major physical disability and psychological problem were not considered for the study. Self-esteem and coping scale were administered to the children with borderline intelligence and average intelligence. The scales were scored appropriately. Mean, SD and 't' value were determined to compared difference between borderline intelligence and average intelligence children on self esteem and coping by using the t-test.

Result confirmed that there were the children with average intelligence showed significantly less self esteem than children with borderline intelligence. As there was significant difference in self esteem between children with borderline intelligence and average intelligence, the results are not according to the hypothesis stated that there will be no significant difference in self-esteem between borderline intelligence and average intelligence children.

The children with borderline intelligence show significantly less active coping than children with average intelligence. The children with borderline intelligence show significantly less avoid coping than children with average intelligence. The children with borderline intelligence show significantly less support coping than children with average intelligence. As there was significant difference in active coping, avoid coping and support coping between children with borderline intelligence average intelligence, the results are not according to the hypothesis stated that there will be no significant difference in support coping between borderline intelligence and average intelligence children.

Keywords: *Self-Esteem, Coping, Children, Intelligence.*

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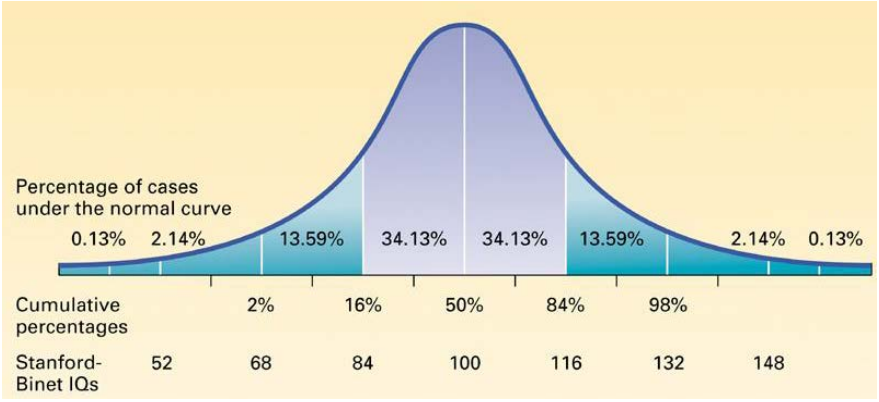
Intelligence is the ability to solve problems and to adapt to and learn from life's everyday experiences. The ability to solve problems The capacity to adapt and learn from experiences Includes characteristics such as creativity and interpersonal skills The mental abilities that enable one to adapt to, shape, or select one's environment The ability to judge, comprehend, and reason The ability to understand and deal with people, objects, and symbols The ability to act purposefully, think rationally, and deal effectively with the environment **Intelligence Quotient (IQ)** : Measure of intelligence that takes into account a child's mental and chronological age. Mental age (MA): the typical intelligence level found for people found for people at a given chronological age. Chronological age (CA): the actual age of the child taking the intelligence test people whose mental age is equal to their chronological age will always have an IQ of 100. If the chronological age exceeds mental age – below-average intelligence (below 100). If the mental age exceed the chronological age-above-average intelligence (above 100).



The normal distribution: most of the population falls in the middle range of scores between 84 and 116.

Very superior Intelligence (gifted)-Above 13
Superior Intelligence - 120 to 129
High Average Intelligence - 110 to 119
Average Intelligence - 90 to 109
Intelligence – 80 to 89
Borderline Intellectual Functioning -71 to 79
Mild Mental Retardation - 55 to 70
Moderate Retardation - 40 to 54
Severe Mental Retardation -25 to 39Low Average
Profound Mental Retardation – Below 25

Intelligence tests were developed for the practical function of selection of selecting students for admission or placement in schools. Originally these tests were not based on any theory of intelligence. They defined intelligence as the ability to do well in school.

BORDERLINE INTELLECTUALS

Borderline intellectual functioning is a cognitive impairment that applies to people who have lower than average intelligence but do not have intellectual developmental disorder or mental retardation. Borderline intellectual functioning is diagnosed by IQ test scores that are between 71 and 84.Borderline intellectual functioning refers to estimated intelligence quotient scores within the 70 to 75 range on intelligence test with an average of 100 and standard deviation of 15. The

range is called borderline because it is on the borderline of the criteria for diagnosis of intellectual disabilities (historically referred to as mental retardation) in the Diagnostic and Statistical Manual of Mental Disorders.(DSM)

Examples: Consistent scores within the 70 to 75 range are considered suggestive of borderline intellectual functioning and may indicate a mental disability. However, it is recommended that multiple test instruments be administered to confirm a diagnosis. No diagnosis should be made on the basis of a single test.

Borderline intellectual functioning, also called borderline mental retardation, is a categorization of intelligence wherein a person has below average cognitive ability (generally an IQ of 70-85), but deficit is not as severe as intellectual disability (below 70). It is sometimes called below average IQ (BAIQ). This is technically a cognitive impairment however; this group is not sufficiently mentally disabled to be eligible for specialized services. Additionally, the DSM-IV-TR codes borderline intellectual functioning as V62.89, which is generally not a billable code, unlike the codes for mental retardation.

During school years, individuals with borderline intellectual functioning are often "slow learners". Although a large percentage of this group fails to complete high school and can often achieve only a low socioeconomic status, most adults in this group blend in with the rest of the population.

AVERAGE INTELLIGENCE

The narrow definition of IQ is a score on an intelligence test … where 'average' intelligence, that is the median level of performance on an intelligence test, receives a score of 100, and other scores are assigned so that the scores are distributed normally about 100, with a standard deviation of 15.

Intelligence tests are one of the most popular types of psychological tests in use today. On the majority of modern IQ tests, the average (or mean) score is set at 100 with a standard deviation of 15 so that scores conform to a normal distribution curve. This means that 68 percent of scores fall within one standard deviation of the mean (that is, between 85 and 115), and 95 percent of scores fall within two standard deviations (between 70 and 130). Why is the average score set to 100? Psychometritians utilize a process known as standardization in order to make it possible to compare and interpret the meaning of IQ scores. This process is accomplished by administering the test to a representative sample and using these scores to establish standards, usually referred to norms, by which all individual scores can be compared. Since the average score is 100, experts can quickly can quickly assess individual test scores against the average to determine where these scores fall on the normal distribution.

Intelligence tests are designed to measure what is known as crystallized and fluid intelligence. Crystallized intelligence involves your knowledge and skills you have acquired throughout your life while fluid intelligence involves your ability to reason, problem-solve, and make sense of abstract information administered by a licensed psychologist. There are different kinds of intelligence test, but many involve a series of subtests that are designed to measure mathematical abilities, language skills, memory, reasoning skills, and information – processing speed. Scores on theses on these subtests are then combined to form an overall IQ score.

One's IQ score might be a good general indicator of your reasoning and problem – solving abilities, but many psychologists suggest that these tests don't tell the whole story. A few things they don't measure are practical abilities and talents. one might have an average IQ score, but you might also be a great musician, a creative artist, an amazing singer, or a mechanical whiz.
Researchers have also found that IQ scores can change over time. One study looked at the IQ's of teenage subjects during early adolescence and then again four years later. The results revealed that scores varied as much as 20 points over that four – year period.

IQ tests also fail to address things like how curious indies are about the world around and how good is at understanding and managing emotions. Some experts, including writer Daniel Goleman, suggest that emotional intelligence (often referred to as EQ) might actually be more important than IQ. And researchers have found that while having a high IQ can certainly give people and edge in many areas of life, it is certainly no guarantee of life success.

So one need not stress out if one is not a genius, since the vast majority of people aren't geniuses either. Just as having a high IQ doesn't ensure success, having an average or low IQ doesn't ensure failure or mediocrity. Other factors such as hard work, resilience, perseverance, and overall attitude are important pieces of the puzzle.

SELF-ESTEEM

One might have heard and seen similar words like "self – image". "Self perception." And "self – concept". All these terms refer to the way we view and think about ourselves. As human beings, we have the ability to not only be aware of ourselves but also to place a value or a measure of worth to ourselves or aspects of ourselves. So, self – esteem mutually refers to how we view and think about ourselves and the value that we place on ourselves as a person. Having the human capacity to judge and place value to something is where we might run into problems with self – esteem.

Self-esteem is similar to self-worth (how much a person values himself or herself). This can change from day to day or from year to year, but overall self-esteem tends to develop from infancy and keep going until we are adults.

Self-esteem also can be defined as feeling capable while also feeling loved. A child who is happy with an achievement but does not feel loved may eventually experience low self-esteem. Likewise, a child who feels loved but is hesitant about his or her own abilities can also develop low self-esteem. Healthy self-esteem comes when a good balance is maintained.

Patterns of self-esteem start very early in life. The concept of success following effort and persistence starts early. Once people reach adulthood, it's harder to make changes to how they see and define themselves.

So, it's wise to think about developing and promoting self-esteem during childhood. As kids try, fail, try again, fail again, and then finally succeed, they develop ideas about their own capabilities. At the same time, they're creating a self-concept based on interactions with other people. This is why parental involvement is key to helping kids form accurate, healthy self-perceptions.

Parents and caregivers can promote healthy self-esteem by showing encouragement and enjoyment in many areas. Avoid focusing on one specific area; for example, success on a spelling test, which can lead to kids feeling that they're only as valuable as their test scores.

COPING

Oping pretty much describes all the different things people do to manage and reduce the stress they feel as a result of issues, problems or difficult situations that occur. Everyone experiences different levels of stress, and also have different ways of coping, which is completely fine. There isn't a 'right' way to cope – different strategies work well for different people, depending on their personal strengths and skills. Despite this, some coping strategies are seen as less beneficial, because they reduce stress temporarily, but don't reduce it in the long run (and often have other bad impacts). Drugs and alcohol are examples of less effective, and sometimes damaging coping strategies. Positive coping skills are any strategies which people find to reduce stress effectively without future backlash. It is these skills you want to develop to help you manage stressful circumstances.

When good coping strategies help

Everyone has setbacks in life. Problems can crop up when we least expect, and it's pretty normal for some issues to hang around for a while. This can be particularly the case in situations that aren't straightforward to fix. Effective coping is great for all sorts of life dramas - whether they're relatively minor problems, or larger scale disasters. Examples of life events that require some kind of coping skills include

Exam/study pressures natural disasters – e.g. floods, fires, drought relationship conflict or break downs serious illness. How we choose to manage these sorts of situations can have a big impact on the outcome of the situation, as well as the long-term effects on our mental health.

METHODOLOGY

Aim:

- To study self esteem and coping among children with borderline intelligence and average intelligence.

Objectives*:*

- To study the difference in self-esteem between borderline intelligence and average intelligence children.
- To study the difference in coping between borderline intelligence and average intelligence children.

Hypotheses:

- There will be no significant difference in self-esteem between borderline intelligence and average intelligence children.
- There will be no significant difference in coping (active coping, avoid coping and support coping) between borderline intelligence and average intelligence children.

Independent Variable*:*

- Children with borderline intelligence and average intelligence.

Dependent Variable*:*

- Responses on self-esteem and coping scale.

Sample:

The sample comprised of 30 each of borderline intelligence and average intelligence children, age ranged between 8 to12 years.

Inclusion Criteria:

Both boys and girls were considered for the study.

Children studying in 4^{th} to 6^{th} standard were considered for the study.

Children identified as borderline intelligence on Colored Progressive Matrices and reported by teacher were considered for the study. Children identifies as average intelligence on Colored Progressive Matrices and reported by the teacher were considered for the study.

Exclusion Criteria:

Children with any major physical disability and psychological problem were not considered for the study.

Research Design:

Between groups design with purposive sampling was opted for the study.

Tools And Description:

1. Demographic data sheet (Prepare for the study)
2. The Culture Free Self-Esteem Inventory for Children (Battle, 1981).
3. Children's coping strategies checklist (Pitts, Tein and Sandler, 1995).

1. Demographic data sheet (Prepare for the study)

This was constructed for the study to obtain identifying background information about the child such as name, age, school, sex, class, birth order, family type etc.

2. Culture Free Self-Esteem Inventory for Children (Battle, 1981)

The inventory has been developed by Battle (1981). It is a 60-item questions/statement classifiable into 4 subscales. Each question or statement is answered in terms of Yes/No. The 4 subscales are: general self-esteem; social and peer related self-esteem; academic and school related self-esteem; parents and home related self-esteem. An analysis of internal consistency based on the normative sample yielded average coefficient alpha reliabilities (across all age categories) generally in the 0.80's. Furthermore, when sorted by gender, ethnicity, and disability classification, the data generally demonstrated coefficient alpha reliabilities in the 0.80's - suggesting that the instrument is consistent across these categories. A sample of (77) individuals (33 Primary-aged, 20 intermediate aged and 24 adolescent) were tested twice with the culture free self-esteem inventory (CFSEI-3) in a two-week period- average correlations between test scores fell in the (.70s) and (.90s) across all age groups and scales. The authors validated the culture free self-esteem inventory (CFSEI)-3 by comparing its scores with other related tools using three age-category samples. The first study compared the culture free self-esteem inventory (CFSEI-3) with the self-esteem index (SEI), the GSEQ score correlated (.61) with the SEI self-esteem quotient. The second study compared culture free self-esteem inventory (CFSEI-3) scores with scores from the Piers-Harris children's self- concept scale (PHCSCS) total score correlated (.72) with the culture free self-esteem Inventory (CFSEI-3) GSEQ. A third study compared CFSEI-3 scores with scores from the multidimensional self concept scale (MSCS) using the adolescent sample. According to the manual, MSCS total scores correlated (.78) with culture free self-esteem inventory (CFSEI-3).

3. Children's coping strategies checklist (Pitts, Tein and Sandler, 1995)

The active coping factor is comprised of the problem focused coping subscales, which are Cognitive Decision Making (CDM), Direct Problem Solving (DPS), and Seeking Understanding (SU) and the Positive Cognitive Restructuring subscales, which are Positivity (POS), Control (CON), and Optimism (OPT). The Avoidant Coping factor is composed of the following subscales; Avoidant Actions (AVA), Repression (REP), and Wishful Thinking (WISH). The Support Seeking Strategies are the Support for Action (SUPA) and the Support for Feelings (SUPF) subscales. The test-retest reliability coefficients for the individual subscales and the four factors are as follows: Individual Subscales (n=65), Cognitive Decision Making (.68), Direct Problem Solving (.66), Positive Cognitive Restructuring (.71), Seeking Understanding (.56),

Physical Release of Emotion (.71), Distracting Action (.70), Avoidance Action (.49), Cognitive Avoidance (.61), Problem Focused Support (.75), Emotion Focused Support (.73).

Plan:

The self-esteem scale and coping scale was administered to the children with borderline intelligence and average intelligence aged between 8-12 years and studying in 4th to 6th standard. The mean scores of self esteem and coping were compared between the children with borderline intelligence and average intelligence to analysis the significant difference on self-esteem and coping scale between borderline intelligence and average intelligence children using the t- test.

Procedure*:*

Children aged between 8-12 years and studying in 4th to 6th standard full filling inclusion criteria i.e. Children identified as borderline intelligence and average intelligence on Colored Progressive Matrices, and not falling under exclusion criteria, i.e. Children with special needs and children with major physical disability and psychological problem and willing to be part of the study were administered self-esteem and coping scale. The scales were scored appropriately. Mean, SD and't' value were determined to compared difference between borderline intelligence and average intelligence children on self esteem and coping by using the t-test.

Analysis of Result:

The scales were scored and the mean values of dependent variable self-esteem scale and coping scale were compared to analyses the difference between children with borderline intelligence and average intelligence using t-test.

RESULTS AND DISCUSSION

The aim of the experiment was to study the self esteem and coping among children with borderline intelligence and average intelligence. Children aged between 8-12 years and studying in 4th to 6th standard full filling inclusion criteria i.e. Children identified as borderline intelligence and average intelligence on Colored Progressive Matrices, and not falling under exclusion criteria, i.e. Children with special needs and children with major physical disability and psychological problem and willing to be part of the study were administered self-esteem and coping scale. The scales were scored appropriately. Mean, SD and 't' value were determined to compared difference between borderline intelligence and average intelligence children on self esteem and coping by using the t-test.

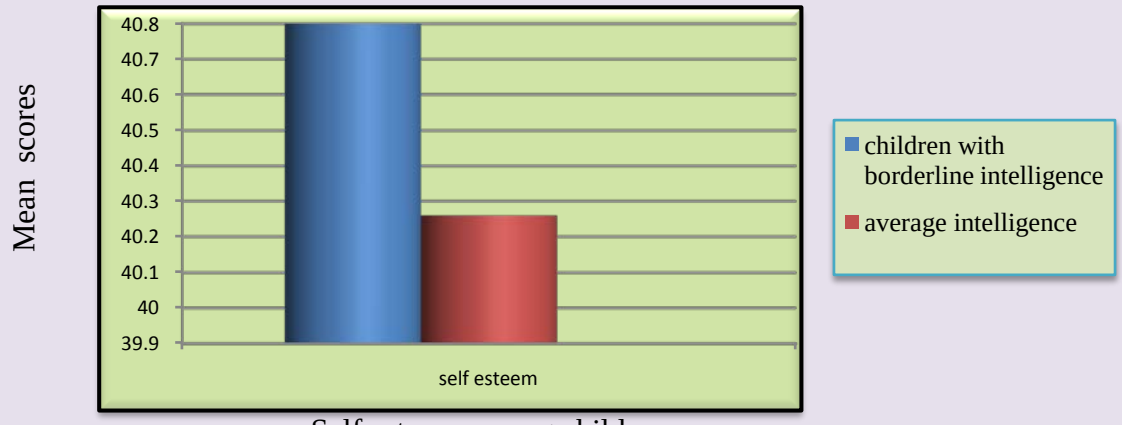
Table: 1 showing the demographical details of the children with borderline intelligence and average intelligence:

Details	borderline intelligence				average intelligence			
	Govt.		Private		Govt.		Private	
	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys
N	8	7	5	10	5	10	9	8
Age	8-12 years				8-12 years			
class	4rd to 6th standard				4rd to 6th standard			

Table: 2 showing the of mean, SD and 't' value on the self esteem and coping among children with borderline intelligence and average intelligence:

AREAS	GROUP	MEAN	SD	t
Self esteem	Children with borderline intelligence	40.80	13.02	0.16*
	Children with average intelligence	40.26	12.47	
Active coping	Children with borderline intelligence	39.76	13.16	1.34
	Children with average intelligence	44.00	11.23	
Avoid coping	Children with borderline intelligence	33.83	8.25	.87*
	Children with average intelligence	35.60	7.43	
Support coping	Children with borderline intelligence	26.66	6.00	0.36*
	Children with average intelligence	27.23	5.93	
P>/0.05* (significant at 0.05 level),				

Graph 1 Showing the self esteem of children with borderline intelligence and average intelligence.



Self esteem among children

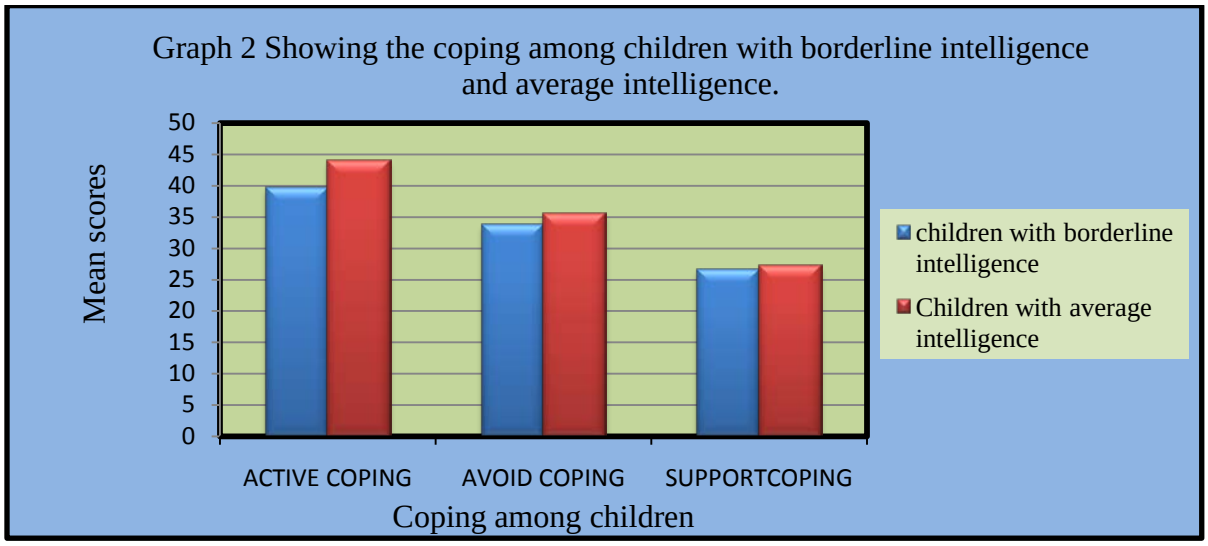


Table 1 shows the demographic details of 60 individuals who were the sample for the study. Of the 60 individuals, 30 were borderline intelligence and 30 were average intelligent studying in government and private school. The age of these individuals ranged between 8-12 years, of which 15 girls and 15 boys were borderline intelligence and 15 boys and 15 girls were average intelligence respectively. Of which 4 borderline intelligence boys belonged to 8-9 years category, 4 borderline intelligence boys belonged to 9-10 years category, 4 borderline intelligence boys belonged to 10-11 years category and 5 borderline intelligence boys belonged to 11-12 years category. 3 borderline intelligent girls belonged to 8-9 years category, 3 borderline intelligence girls belonged to 9-10 years category, 3 borderline intelligence girls belonged to 10-11 years category and 4 borderline intelligence girls belonged to 11-12 years category. 2 average intelligent boys belonged to 8-9 years category, 4 average intelligent boys belonged to 9-10 years category, 2 average intelligent boys belonged to 10-11 years category and 3 average intelligent boys belonged to 11-12 years category. 4 average intelligent girls belonged to 8- 9 years category, 5 average intelligent girls belonged to 9-10 years category, average intelligent girls belonged to 10-11 years category and 5 average intelligent girls belonged to 11-12 years category.

Table 2 shows the Mean, SD and ‘t’ value obtained for esteem and coping among children with borderline intelligence and average intelligence. For self esteem the mean secured by children with borderline intelligence and average intelligence were 40.80 and 40.26 respectively, with ‘t’ value being 0.16 which was significant at 0.05 level, indicating that there was significant difference in self esteem between children with borderline intelligence and average intelligence. The children with average intelligence show significantly less self esteem than children with borderline intelligence. The results are not according to the hypothesis stated that there will be no significant difference in self-esteem between borderline intelligence and average intelligence children.

For active coping the mean secured by children with borderline intelligence and average were 39.76 and 44.00 respectively, with 't' value being 1.34 which was significant at 0.05 level, indicating that there was significant difference in active coping between children with borderline intelligence and average intelligence. The children with borderline intelligence show significantly less active coping than children with average intelligence. The results are not according to the hypothesis stated that there will be no significant difference in active coping between borderline intelligence and average intelligence children.

For avoid coping mean secured by children with borderline intelligence and average were 33.83 and 35.60 respectively, with 't' value being .87 which was significant at 0.05 level, indicating that there was significant difference in avoid coping between children with borderline intelligence and average intelligence. The children with borderline intelligence show significantly less avoid coping than children with average intelligence. The results are not according to the hypothesis stated that there will be no significant difference in avoid coping between borderline intelligence and average intelligence children.

For support coping mean secured by children with borderline intelligence and average were 26.66 and 27.23 respectively, with 't' value being 0.36 which was not significant at 0.05 level, indicated that there was no significant difference in support coping between children with borderline intelligence and average intelligence. Though there was no significant difference in coping children with borderline intelligence showed less support coping than children with average intelligence. The results are not according to the hypothesis stated that there will be no significant difference in support coping between borderline intelligence and average intelligence children.

The graph 1 shows the self esteem among children with borderline intelligence and average intelligence. The bar graph indicates an inclination in the self esteem for children with average intelligence than the children with borderline intelligence.

The graph 2 also shows the active coping, avoid coping, and support coping among children with borderline intelligence and average intelligence. The bar graph shows an inclination in bar for all coping methods for borderline intelligence than for average intelligence.

CONCLUSION

The children with average intelligence showed significantly less self esteem than children with borderline intelligence.

As there was significant difference in self esteem between children with borderline intelligence and average intelligence, the results are not according to the hypothesis stated that there will be no significant difference in self-esteem between borderline intelligence and average intelligence children.

The children with borderline intelligence show significantly less active coping than children with average intelligence.

As there was significant difference in active coping between children with borderline intelligence average intelligence, the results are not according to the hypothesis stated that there will be no significant difference in active coping between borderline intelligence and average intelligence children.

The children with borderline intelligence show significantly less avoid coping than children with average intelligence.

As there was significant difference in avoid coping between children with borderline intelligence average intelligence, the results are not according to the hypothesis stated that there will be no significant difference in avoid coping between borderline intelligence and average intelligence children.

The children with borderline intelligence show less support coping than children with average intelligence.

As there was no significant difference in support coping between children with borderline intelligence average intelligence, the results are according to the hypothesis stated that there will be no significant difference in support coping between borderline intelligence and average intelligence children.

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Situation and Personality Effects on Smokers' Psychological Reactance

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ABSTRACT

This paper tries to investigate the situational and personal aspects that may trigger smokers' psychological state reactance. It was hypothesized that situational factors, such as perceived threat to freedom and perceived loss of control which are supposed to be triggered by an anti-smoking persuasive message, and a personality pattern, such as trait reactance proneness, predict the psychological state reactance. An experiment and a survey were conducted on a random sample of 352 smoking students in two Tunisian business schools. Four anti-smoking print ads, with two different levels of negative emotional intensity, were manipulated. The findings depict the importance of the anti-smoking ads with a high negative emotional intensity, the perceived threat to freedom and trait reactance proneness in the smokers' psychological reactance prediction.

Keywords: *Partial Least Square, Persuasion, Self-Control, Smoking, Structural Equation Modeling.*

In spite of the increasingly emerging literature focusing on persuasive message effectiveness, several persuasion-related issues are having not received sufficient scholarly attention and need to be further addressed. Recent research highlights the importance of incongruity between an individual's prior expectations and the content of a persuasive message (Nesterkin, 2013). This mismatch is mainly related to the individual disagreement with the persuasive attempts especially when the persuasive message is perceived to be characterized by constraints in terms of choice, thinking and behavioral freedoms (Seltzer, 1983). Accordingly, hardly has the problem of freedom been discussed in marketing literature because people are always considered as free by nature (Darpy and Allaz, 2006). However, freedom is one of the most vitally important human values (Jonas et al, 2009) that can be restricted. In fact, people want to maintain their freedom of thought, feeling and action (Donnell et al, 2001). The protection motivation theory and threat avoidance theory advocate in this sense that individuals tend to take adaptive

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protective measures whenever they perceive a threat (Ilie, 2013). In this respect, they often show an aversion toward losses and they may experience psychological reactance (Edwards et al, 2002). Bhattacharjee (2010) emphasizes that psychological reactance is a mechanism critical to individual functioning and it is a crucial avenue for future consumer behavior research. The theory of psychological reactance (Brehm, 1966) suggests that persuasion can arouse motivation for avoidance of any advocated idea (Darpy and Allaz, 2008). In this respect, psychological reactance appears as a construct that may have multiple implications in several persuasion fields (Buboltz et al, 2003). Furthermore, reactance theory might be profitably applied to understanding failures in persuasive health communication (Dillard and Shen, 2005). It seems to be best suited to the anti-smoking persuasion context especially with the increasingly high rate of reluctant smokers and an increasing tendency to reject anti-smoking messages. Indeed, the World Health Organization (WHO) emphasizes that, despite the decrease of smoking rate in Tunisia over the past five last years or so, this rate is still high. This phenomenon has become increasingly worrying for the Tunisian society and attracted social researchers' and practitioners' attention. Previous research found that the increasing consumption of cigarettes reflects high resistance to anti-smoking persuasion. Furthermore, a wide range of studies have been conducted on resistance to persuasion to better understand the reasons for which smokers reject anti-smoking persuasive messages (e.g.. Knowles and Linn, 2004).

At this stage, one may ask how people become reactant toward anti-smoking persuasive messages. The marketing literature highlights, in this regard, the existence of several situational and personality factors that may explain the psychological reactance process (Silvia, 2006).

This research tries to investigate, through a theoretical overview and an empirical study, the smokers' psychological reactance process by integrating situational and dispositional predictors of reactance.

THEORETICAL BACKGROUND

To bring more insight on the psychological reactance mechanism, an understanding of reactance extent, as well as, its predictors is quite important for social marketers.

Psychological reactance

Freedom is the essential tenet of the theory of psychological reactance which is derived from the free-choice paradigm (Brehm, 1966). Freedom is defined as a person's belief in their ability to engage in a certain behavior and to decide on the type of behavior, as well as how and when it should be performed (Brehm and Brehm, 1981). It is treated as an unconstrained ability to choose from any available alternatives, and any attempt to either eliminate or curtail the alternatives may present a threat to freedom (Kim et al., 2014). In this sense, psychological reactance refers to the counterforce to a threat to freedom (Kim et al., 2014) and is considered as a motivational state directed toward the re-establishment of free behaviors that have been eliminated, reduced or threatened (Shen, 2014: Woller et al., 2007; Darpy and Allaz, 2006; Mason, 2003). Hence, researches assert that reactance is plausibly viewed as an individual

negative reaction, an anti-conformity (Grabitz-Gniech, 1971), a counter-argumentation (Rains, 2013) and a motivation for message rejection (Mourali and Yang, 2013; Clee and Wicklund, 1980) involving a combination of affect, particularly anger, and unfavourable cognitions toward advertising (Rains and Turner, 2007; Ringold, 2002). Kim et al. (2014) define anger in this respect as a reasoned emotion ensuing unfavorable rational judgment of the counterparts' provocative speech acts. That is, the intertwined model of psychological reactance depicts reactance as an amalgam of anger and counter-argumentation (Shen, 2014; Quick et al., 2013 Rains, 2013). It provides the special case of a synergistic model of attitudes via the interplay of cognitive and affective patterns which predicts the failure of a persuasive endeavour (Kim et al., 2014). Hence, according to the theory of cognitive dissonance (Festinger, 1957), when two or more cognitions are inconsistent with one another, a disruptive state of 'dissonance' is triggered. Individuals are therefore highly motivated to cope with such awkward situation (Risen and Chen, 2010) and to do their best to maintain their internal consistency (Laurin et al., 2012). Wiium et al. (2009) state that '*Psychological reactance serves an important function in people's lives and trying to restore one's freedom may be understood as a healthy aspect*'. In this sense, psychological reactance is often regarded as one form of individual resistance that may be triggered by persuasive attempts (Knowles and Linn, 2004). The literature in psychology points out that the magnitude of psychological reactance increases as the expectancy of freedom, the importance of freedom and the proportion of threatened freedoms increase (Shen, 2014; Quick, 2013). Indeed, the expectancy of freedom includes only behaviors that can be reasonably considered as free behaviors (like smoking). The importance of freedom by implication means the importance of free behaviors which are eliminated or threatened (tobacco consumption seems a very urgent need especially for highly addicted people). The proportion of threatened freedoms reflects the number of free behaviors eliminated or threatened compared to the general amount of freedoms an individual has. Otherwise, individuals experiencing a high level of psychological reactance tend to increase preference for the eliminated option(s), derogate the message source, maintain current attitudes (Kim et al., 2014) and show high resistance to persuasion.

The situational predictors of smokers' psychological reactance

The psychological reactance process includes a variety of situational and individual factors. In this research, four main factors were studied: anti-smoking persuasive message, perceived threat to freedom, perceived loss of control and trait reactance proneness.

Anti-smoking persuasive message

Anti-smoking communication has often used highly negative emotional appeals as a main persuasive tactic to motivate smokers to quit smoking. More precisely, high fear appeals were the most operationalized technique in such a communication. Highly fearful messages are a persuasive tool that aims to evoke fear to enhance motivation for precaution. They often carry harsh, frightening and threatening pictures that may offend the audience's sensitivity. Indeed, fear appeal derives its strength from its ability to generate highly negative emotions (Eppright et

al, 2002). Although research advocates the effectiveness of the fear appeal in attitudinal and behavioral changes (Gallopel-Morvan et al, 2010; Gallopel, 2005), other researches assert that it functions as a barrier to successful persuasion (Girandola and Michelik, 2008; Dillard and Nabi, 2006). Indeed, message features such as fear appeals as well as strong, dogmatic and controlling language may increase or decrease individuals' psychological reactance (Quick et al., 2015; Shen, 2014; Laurin et al., 2012). Assael (2005) emphasizes, in this regard, that the use of fear is tough since a level of fear that is too high triggers various defensive mechanisms, such as psychological reactance. Negative emotional appeals, such as fear arousal, may evoke a combination of affective and cognitive negative evaluations (Kim et al., 2014). That is, individuals often do not recognize the negative effects exposure to messages exert on them (Varava and Quick, 2015). They may develop cognitions that cannot be in accordance with a given persuasive message (Rains, 2013). Such cognitions make them consider the influence attempt underlying the message and aiming to shape, reinforce or change attitudes, as a threat to freedom (Shen, 2014). Individuals are unlikely to feel that they will be punished if they eliminate their current behaviour (Wright and Palmer, 2012). They experience, therefore, high psychological reactance.

Perceived threat to freedom

Reactance often increases when freedom is perceived as highly limited. That is, the amount of psychological reactance is positively correlated with the amount of threatened freedom (Quick et al., 2015; Varava and Quick, 2015; Jung, 2010). The perceived threat to freedom depends on the degree of importance attached to such freedom; the more the freedom is important for the individual, the stronger the perceived threat and greater the psychological reactance would be (Varava and Quick, 2015; Jonas et al, 2009; Clee and Wicklund, 1980). The threat would be seen as such strong when the individual makes an inference that lets him perceive the threat as general, limiting all his own behaviors and likely to occur repeatedly in the future (Chartrand et al. 2007). In the same perspective, fear arousal is assumed to cause a message to be rejected since a high level of fear may make individuals perceive a loss of freedom (Girandola and Michelik, 2008). Indeed, '*although a highly negative health message source may have good intentions; the person whose freedoms are threatened or removed is unlikely to see it that way*' (Miller et al, 2007). For this reason, the perception of an advertisement as highly intrusive should be considered as a negative cognitive evaluation of the degree to which the advertisement disrupts a person's goals or freedom (Edwards et al. 2002). Furthermore, '*threats to freedom that emanate from the social-influence attempts, like persuasive messages, increase as the externally-imposed pressure to change increases*' (Clee and Wicklund, 1980). High externally-imposed pressure may be materialized in a high negative anti-smoking message that may involve pressure to change attitudes, beliefs and behaviors (Ringold, 2002). In a recent study, Quick et al. (2011) point out that exposure to television ads warning against the dangers of smoking marijuana could reasonably be perceived as a threat to a legitimate freedom, which, in turn, would stimulate reactance. Following this rationale, it seems plausible to note that an anti-smoking message with a highly negative emotional intensity makes smokers perceive a great threat to their freedom. In

turn, a great perceived threat to freedom gives rise to the smokers' willingness to re-establish the threatened freedom of smoking and triggers high psychological reactance. Indeed, loss-frame messages produce negative emotion, such as fear, guilt and anger, which are related to a greater perception of threat to freedom and psychological reactance (Quick et al., 2015). Accordingly, we can hypothesize :

H1: *A highly negative anti-smoking persuasive message positively influences perceived threat to freedom.*

H2: *Highly perceived threat to freedom positively influences smokers' psychological (state) reactance.*

Perceived loss of control

In social psychology, the concept of freedom is frequently observed in the context of control (Jonas et al, 2009). Quick (2005) asserts, on the basis of the theory of psychological reactance, that control and freedom are intimately linked. Thus, psychological reactance can be activated due to the perceived loss of control (Dowd, 1993). Perceived loss of control can be defined as '*the degree to which a consumer feels a loss of control in conducting their own tasks due to the exposure to intrusive ads*' (Morimoto and Chang, 2006). In this sense, individuals should maintain cognitive, emotional, physical, and psychological abilities to perform the threatened or eliminated action (Quick, 2013). If an individual has control over a behavior, they are assumed to possess the necessary skills and abilities to perform such a behavior (Quick, 2005). Nevertheless, when they lose control they become more reactant, especially when they perceive that it is possible to restore their control (Miller et al, 2007; Hellman and McMillin, 1997). Yet, Brehm (in Dowd, 1993) asserts that reactance refers to control motivation. Control motivation is an internal state aimed at regaining control over an outcome (Quick, 2005). This kind of motivation is mainly due to a perceived lost or threatened control (Quick, 2005). Hence, the control motivation suggests that individuals should have control over themselves and situations (Dowd, 1993; Ringold, 2002). That is, situations may provoke unwanted marketing communication messages, such as the anti-smoking ones. As a result, smokers may feel loss of control over their own behaviors (Morimoto and Chang, 2006). As Morimoto and Chang (2006) note, 'the theory of psychological reactance suggests that when individuals frequently act counter to restrictions or pressures put upon them by external sources, they are likely to react against threats or loss of control by acting in the opposite way that was intended by the source' (Morimoto and Chang, 2006). Yet, the use of fear is not necessarily an effective means of persuasion, but rather a cause of reactance because people do not feel able to control the highly threatening message with a set of highly manipulative and authoritarian characteristics leading people to repudiate the frightening information (Girandola and Michelik, 2008).

In sum, a highly negative anti-smoking persuasive message seemingly increases the perception of loss of control over attitudes and behaviors that leads to the activation of the smokers' psychological reactance. Accordingly, the two following hypotheses can be formulated:

H3: *A highly negative anti-smoking persuasive message positively influences the smokers' perceived loss of control.*
H4: *A highly perceived loss of control positively influences the smokers' psychological (state) reactance.*

Trait reactance proneness as a dispositional predictor

Researchers point out that reactance theory was originally hypothesized to be situation-specific, but individuals chronically differ in terms of their levels of trait reactance proneness (Jung, 2010; Hong and Faedda 1996). Trait reactance is generally a one-dimensional construct (Hong and Faedda, 1996) that refers to a personal characteristic that people show and that can fluctuate over life stages (Miller et al, 2007). Hence, Wiium et al. (2009) define dispositional reactance as '*people's general tendency to react negatively toward any kind of threats to their behavioral freedom*'. Accordingly, reactant people tend to be aggressive, dominant, and defensive; they can take quick offensive positions; they are individualistic and they usually retain unfavourable impressions toward others (Dowd, 1993; Dowd and Wallbrown, 1993). Reactant individuals are powerful and enjoy a disproportionate access to valuable resources, such as knowledge (Friestad and Wright, 1999), and have greater control over their own and others' outcomes (Mourali and Yang, 2013). Researchers emphasize that trait reactant individuals are likely to experience state reactance due to their strong need for independence and autonomy, confrontational and rebellious behavior, and a tendency to resist authority in general (Quick et al., 2011; Shen and Dillard, 2005, Seibel and Dowd, 2001). They are often motivated by a desire to signal their independence (Mourali and Yang, 2013), show high self-esteem (Wright and Palmer, 2012) and they are less trusting, more vigilant, prone to anxiety and worry, concerned about personal control, and suspicious or distrustful of others (Woller et al., 2007; Dowd and Wallbrown, 1993). Reactant people are characterized by issue-specific competence (Wright and Palmer, 2012), show a high level of coping self-efficacy that makes them rebuff influence attempts (Bandura, 1989) and more desirability for the forbidden behavior (Moore and Fitzsimons, 2014). Dowd et al. (1994) characterized reactant individuals as being less concerned with giving a good impression to others and less likely to conform to social norms. They have a tendency to act without considering potential consequences and tend to be more interested in being themselves than accommodating to the expectations of others (Buboltz et al, 2003). Dowd et al. (1994) noted that psychologically reactant individuals are less concerned with impressing others or adhering to social norms and regulations, somewhat careless about fulfilling duties and obligations, inclined to express strong emotions and feelings, and preoccupied with possible future problems. The authors assert that dispositional reactance should be higher among smokers than among nonsmokers and should be negatively associated with positive attitudes toward tobacco control measures. Hence, Miller and Quick (2010) assume that trait reactant individuals are more inclined to use tobacco products and to engage in risky behaviors.

In accordance with this rationale, it can be hypothesized that:

H5: *Smokers' trait reactance proneness positively influences their psychological (state) reactance.*

The suggested hypotheses form a theoretical model (figure 1).

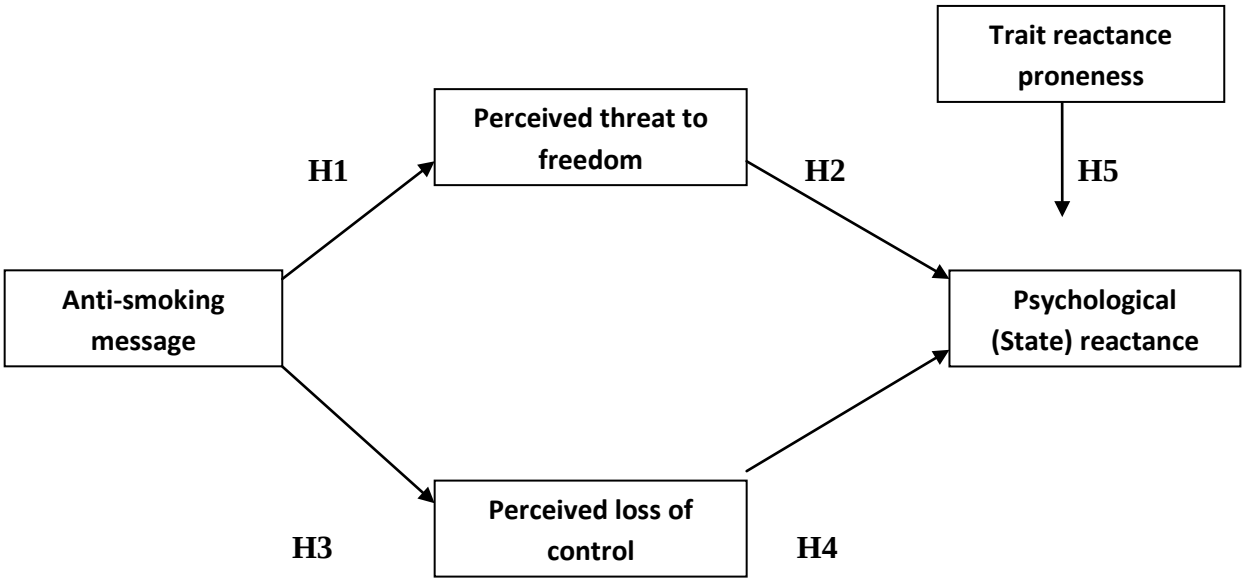

Figure 1: The research model: the psychological reactance mechanism

METHODOLOGY

To check the research model, an empirical approach was adopted. In this respect, a measurement specification and a data collection procedure were implemented.

Measures

To assess the retained constructs, four measurement scales were selected from the literature. Scale specification was performed on the basis of their previously proved psychometric qualities as well as their suitability to the context of this study. All the retained scales are 5-points Likert scales (1: *strongly disagree* and 5: *strongly agree*, see Appendix).

- *Psychological reactance*: state reactance was measured by four items which were used by Dillard and Shen (2005) and derived from the Hong's Reactance Scale of Hong and Faedda (1996). The four items reflected one dimension and had a good reliability level ($\alpha = 0.83$).
- *Trait reactance proneness*: Hong's reactance scale was used again to measure trait reactance proneness (Dillard and Shen, 2005; Hong and Faedda, 1996). More particularly, four other items forming the dispositional factor of reactance were chosen. These selected items were previously

used by Wiium et al. (2009) and showed one single factor. This subscale had a good reliability level ($\alpha = 0.79$) in the work of Dillard and Shen (2005).

- *Perceived threat to freedom*: Perceived threat to freedom was measured by four items used by Dillard and Shen (2005). These items showed one dimension (Jung, 2010) and a good psychometric quality ($M = 3.69$, $SD = 1.65$, $\alpha = 0.85$).

- *Perceived loss of control*: To assess the perceived loss of control, the Therapeutic Reactance Scale –TRS- (Dowd et al, 1991) was retained. This scale is composed of 28 items developed to measure client reactance and can be adopted to the anti-smoking context. Morimoto and Chang (2006) assert that the TRS is best suited to assess perceived loss of control in a reactance-related context. Because of their suitability for the construct meaning, only 12 items were selected to be used. The 12 selected items were the best to represent the perceived loss of control in a persuasion context.

Otherwise, a pilot study was conducted to check the psychometric qualities of the retained scales, a random sample of 80 students at graduate and undergraduate levels was recruited. Then, an exploratory factorial analysis was conducted using SPSS 19. The scales purification allowed eliminating 1 item from the trait reactance proneness scale and 2 items from the perceived loss of control scale because of their low fit quality. The exploratory analysis provided acceptable levels of KMO (> 0.6) and Bartlett sphericity indicators (Chi-square > 0, p=0,000). All the scales, as predicted by the literature, were one-dimensional and indicated satisfactory levels of reliability ($\alpha > 0.75$).

Stimulus selection

Four different print ads were selected from previous research (Gallopel-Morvan et al, 2010; Gallopel, 2005). The four ads were negatively framed and supposed to evoke two different levels of negative emotional intensity (2 high vs. 2 low). The main negative emotion to be manipulated was fear arousal. The two first ads contained two highly negative images that show tobacco-related risks and smokers' vulnerability to hazardous diseases. The other two ads also contained two images that were supposed to be less negative than those of the first ads. These ads encourage smokers to quit smoking in order to escape from the potential risks of tobacco.

A pilot study was performed to check the relevance of the selected print ads. For that purpose, the 5 points' Differential Emotional Scale (Izard, 1977) was retained to measure the smokers' affective and cognitive reactions that might be induced by the print ads. More particularly, only the fear dimension, composed of 3 items (Scared, Frightened, Afraid), was measured. The four ads were tested on the aforementioned random sample of 80 student smokers.

An ANOVA (One-Way ANOVA) was performed thereafter to evaluate the differential effect of the ads on smokers. The findings showed a satisfactory mean difference between the

participants' responses to the fear items, a significant student's t-test (>1.96) threshold and an acceptable F-test (see table 1) ; (high: M (ad 1) = 3.99 ; M (ad 2) = 3.85 ; low: M (ad 3) = 1.89 ; M (ad 2) = 1.53). The items, therefore, had a good internal consistency for the print ads (high: α (ad 1) = 0.850 ; α (ad 2) = 0.863 ; low: α (ad 3) = 0.798 ; α (ad 2) = 0.821).

Table 1: Differential effect of the print ads (ANOVA)

ANOVA F-test		**High fearful print ads**		**Low fearful print ads**	
		Print ad 1	**Print ad 2**	**Print ad 3**	**Print ad 4**
High fearful print ads	**Print ad 1**	-----	3.122 (p=0.000)	19,649 (p=0.000)	25.869 (p=0.000)
	Print ad 2	3.122 (p=0.000)	-------	23.417 (p=0.000)	31.571 (p=0.000)
Low fearful print ads	**Print ad 3**	19,649 (p=0.000)	23.417 (p=0.000)	-------	2.891 (p=0.000)
	Print ad 4	25.869 (p=0.000)	31.571 (p=0.000)	2.891 (p=0.000)	------

Procedures

To collect data, an experiment and a survey were conducted face to face on a random sample of 352 student smoker belonging to two business schools (74 % males and 26 % females). The sample was divided into four groups. Each group was exposed to an anti-smoking print ad for about 2 minutes to let the participants think about the ads' content. After ad exposure, the case-study students were requested to respond to the questionnaire. After data collection, the questionnaires with missed and extreme data were eliminated from the study.

Analysis and results

To test the research model, an exploratory factor analysis was performed first. Then, a confirmatory factor analysis (CFA) was conducted through which the measurement and the structural models were assessed.

Exploratory factor analysis

An exploratory factor analysis (EFA) was performed. This analysis eliminated two other items from the perceived loss of control scale because of their low loading scores. The KMO indicators were acceptable for all the scales (> 0.6) and the Bartlett sphericity indicators were also satisfactory (Chi-square > 0, p=0.000). Hence, in order to investigate the dimensionality of each scale, a principal component analysis was performed. The findings showed that all the scales were one-dimensional and had satisfactory levels of explained variance (psychological reactance: 76.33 %; perceived threat to freedom: 80.17 %; trait reactance proneness: 61.87 % and perceived loss of control: 57.66 %).

Assessment of the measurement models

To assess the measurement models, we implemented the PLS (Partial Least Square) structural equation method. We used XLSTAT-PLS to analyse the data. Although PLS provides a relatively unbiased estimations, the method follows no distributional assumptions and does not present significance levels (Thies and Albers, 2010). In this respect, we applied a bootstrap resampling procedure with 500 iterations to have a better fit.

Reliability

The analysis showed a clear separation of items along construct lines with Eigenvalues greater than 1.0. This already suggested a high level of construct validity. Moreover, reliability was evaluated by assessing the items internal consistency of each factor using Cronbach's alpha. For each extracted dimension, Chronbach's coefficient alpha was > 0.7 which indicated satisfactory reliability as recommended by Nunnally and Bernstein (1994). Yet, we assessed the composite reliability using Dillon-Goldstein cœfficient 'D.G. rho (PCA)'. The findings (table 2) showed satisfactory levels of D.G. rho (> 0.70) for all the estimated constructs in accordance with Fornell's and Larker's (1981) recommendations.

Table 2: The scales composite reliability

Latent variable	Items	Cronbach's Alpha	D.G. rho (PCA)	Eigenvalues
Psychological reactance	4	0.841	0.901	1.643
Perceived threat to freedom	4	0.813	0.888	1.271
Trait reactance proneness	3	0.759	0.821	1.116
Perceived loss of control	8	0.787	0.843	1.894

Convergent validity

Convergent validity was assessed primarily through the loadings factor generated by the PLS algorithm. Through a bootstrap resampling procedure (500 iterations), all the constructs showed high loadings within each factor which indicated good convergent validities. Secondly, we assessed convergent validity through the Average Variance Extracted (AVE). PLS analysis (Table 3) showed acceptable levels of AVE (> 0.5) for each factor in accordance with Fornell's and Larcker's (1981) recommendations, which also indicated a good convergent validity. Thirdly, the analysis provided relatively moderate levels of R^2 for all the measurement models based on Chin (1998) considerations. For R^2adj, the measurement models also showed relatively moderate thresholds. Finally, the findings showed significant levels of D.G. rho of the confirmatory analysis for all the models (> 0.7), which confirmed a good convergent validity.

Table 3: The measurement models assessment

Latent variable	R^2	Adjusted R^2	S.E	Mean Communalities (AVE)	D.G. rho
Psychological reactance	0.367	0.347	0.033	0.678	0.912
Perceived threat to freedom	0.288	0.265	0.041	0.644	0.878
Trait reactance proneness	---	---	---	0.633	0.913
Perceived loss of control	0.252	0.241	0.027	0.623	0.866
Mean	0.302			0.644	

Discriminant validity

Discriminant validity was tested on the basis of Fornell's and Larcker's (1981) approach. This approach indicates that the square root of the Average Variance Extracted (AVE) for each dimension should exceed the correlation estimate between any pair of dimensions. Hence, Fornell and Larcker (1981) point out that it is possible to assess discriminant validity by comparing AVE and the squared correlations between factors that should be < the AVE value. The results shown in table 4 confirmed good discriminant validity between all the dimensions.

Table 4: The discriminant validity assessment

	(AVE)	Psychological reactance	Perceived threat to freedom	Trait reactance proneness	Perceived loss of control
Psychological reactance	0.678	**0.823***			
Perceived threat to freedom	0.644	0.233	**0.802***		
Trait reactance proneness	0.633	0.273	0.167	**0.795***	
Perceived loss of control	0.623	0.400	0.061	0.123	**0.789***

* Square root of the AVE

Assessment of structural model

To assess the structural model, the PLS analysis provides a GoF (Goodness-of-Fit) index that should vary between 0 (model rejection) and 1 (model validation). According to the findings (Table 5), the model can be retained in accordance with Tenenhaus et al.'s (2005) recommendations (GoF=0.671 > 0.5).

Table 5: The structural model fitness

	GoF	GoF (Bootstrap)	Standard error	Critical ratio (CR)
Absolute	0.399	0.347	0.022	16.231
Relative	0.616	0.583	0.016	9.167
Outer model	0.788	0.742	0.009	33.549
Inner model	0.671	0.656	0.005	11.891

Furthermore, the research hypotheses were tested (see figure 2 and table 6). First, the findings showed an acceptable regression weight between the print ad exposure and the perceived threat to freedom (0.517 > 0.5), which allowed retaining **H1**. Second, the effect of perceived threat to freedom on psychological reactance was relatively low (0.483 < 0.5), yet remained very close to the required threshold which could be retained. **H2** is therefore accepted. Third, the print ad seemed inefficient to make smokers perceive loss of control (0.343 < 0.5) and thus **H3** was refuted. Hence, perceived loss of control appeared to not have no significant effect on psychological reactance (0.333> 0.5). **H4** was consequently rejected. Finally, psychological reactance seemed to be well-predicted by the trait reactance proneness (0.523 > 0.5). **H5** was therefore verified.

Table 6: The hypotheses verification

Hypothesis		Estimate	Path coefficient	Student T	Pr > |t|	Effect size f^2
H1	Print ad → Perceived threat to freedom	0.517	0.515	10.213	0.000	0.409
H2	Perceived threat to freedom → Psychological reactance	0.483	0.478	9.621	0.000	0.376
H3	Print ad → perceived loss of control	0.343	0.343	6.456	0.037	0.241
H4	Perceived loss of control → Psychological reactance	0.333	0.332	5.781	0.009	0.226
H5	Trait reactance proneness → Psychological reactance	0.523	0.523	10.467	0.000	0.428

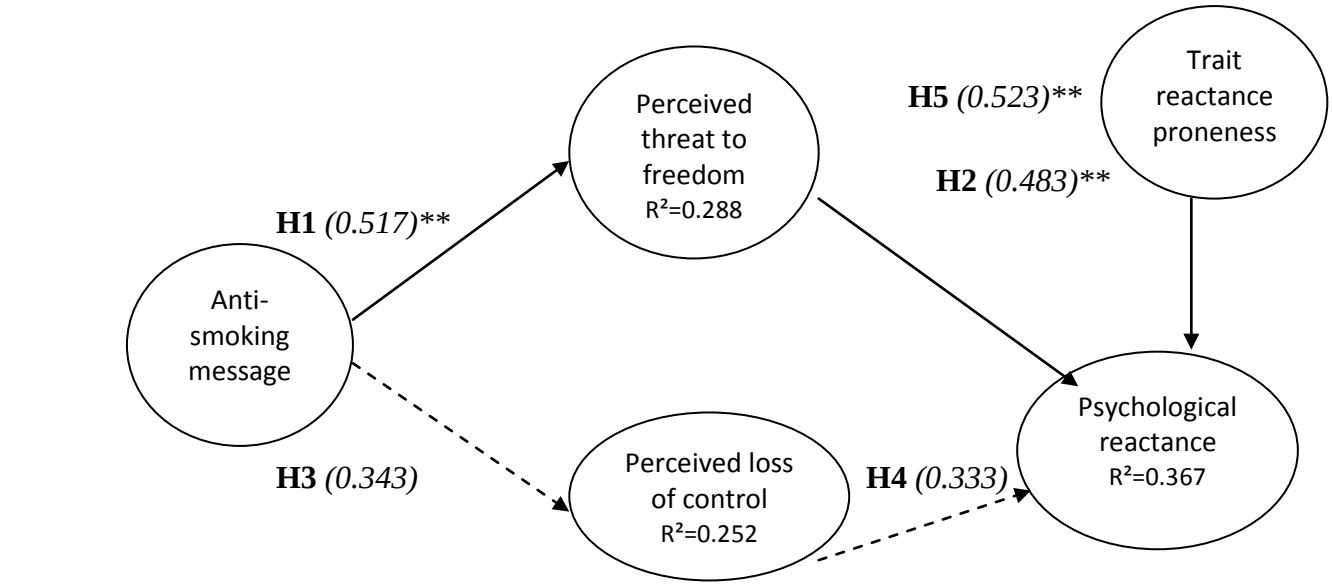

Figure 2: The final model: the psychological reactance

DISCUSSION

The purpose of this research was to investigate smokers' psychological reactance mechanism. In light of the literature review, four main relevant factors may be integrated in the reactance process: highly negative anti-smoking message, perceived threat to freedom, perceived loss of control and trait reactance proneness. The obtained findings supported the suggested model through satisfactory thresholds of the fitness indicators. Yet, psychological reactance seemed to be predicted by the anti-smoking message, through the mediation of perceived threat to freedom, and the trait reactance. In fact, the print ad used in this study seemed effective in evoking threat to freedom that was well-perceived by the smokers under observation (**H1** was accepted**)**. In this respect, the use of negative emotional appeals in anti-smoking print ads seemed relevant in evoking negative psychological reaction. Furthermore, the results showed a positive relationship between the perceived threat to freedom and psychological reactance (**H2** was accepted**)**. These results confirmed the mediating role of the perceived threat to freedom in psychological reactance prediction. The findings are consistent with prior research that showed the relevance of the threat to freedom perception in the psychological reactance process (Jung, 2010; Jonas et al, 2009; Clee and Wicklund, 1980). Moreover, the analysis confirmed the psychological reactance conception as the individual negative reaction to any perceived attempt of freedom limitation or threat (Darpy and Allaz, 2006). This idea seems important for social marketing designers to better understand why Tunisian smokers reject anti-smoking advertisements. In the same perspective, the -smoking print anti ads seemed inefficient in triggering the sense of control loss (**H3** was rejected). In addition, psychological reactance seemed unaffected by the perceived loss of control (**H4** was dismissed). This result is logical since smokers did not perceive a loss of control when they were exposed to the anti-smoking ads. These results are not consistent with previous research that highlighted the importance of perceived loss of control in psychological reactance prediction (Miller et al, 2007; Hellman and McMillin, 1997; Dowd, 1993). Based on the findings, the perceived threat to freedom appeared as a unique mediator in the smokers' psychological reactance process. Finally, the psychological reactance process seemed well-explained by the trait reactance proneness (**H5** was accepted) which is in agreement with findings reported in prior research (Jung, 2010; Miller et al, 2007; Hong and Faedda, 1996). The Tunisian smokers seemed to be reactant by nature and tend to automatically reject all kinds of influence or pressure attempts.

CONCLUSION

The purpose of this research was to investigate smokers' psychological reactance process. According to the discussed results, the perceived threat to freedom, which depends on the highly negative anti-smoking message, appeared as a relevant mediator of the smokers' psychological reactance mechanism. Yet, trait reactance proneness came out as another important factor of the smokers' psychological reactance process.

This study has theoretical implications. In fact, the study has made a relevant contribution to the conceptualisation of psychological reactance, through the determination of its mechanism and its

predictors. This seems to significantly further enrich the existing literature on psychological reactance.

The study has also managerial implications. In fact, the use of high fear appeals in the anti-smoking persuasion triggers more message refutation, materialized in the smokers' psychological reactance, rather than message acceptance. This seems quite important for social marketers to the extent that they should review their negative anti-smoking advertising tactics. More particularly, social marketers should conceive stimuli that should be less manipulative and less threatening to the smokers' freedom or attitudes toward smoking. Hence, Tunisian smokers seem to be reactant by nature. Indeed, social marketers should note that the main reason of the message refutation may be the personality type of smokers. This reasoning may be important to the extent that smokers are likely to deny the anti-smoking message to which they were exposed, not because the message is not actually manipulating or posing threat to freedom, but because they have a durable individual tendency to reject any form of pressure. This seems interesting to consider. Indeed, social marketers should conceive intelligent messages that should not contradict smokers' expectations.

This study is not without limitations. We recruited a random sample of students to test our model which seems not sufficiently representative and may affect the external validity. Hence, other factors may be investigated as potential contributors the smokers' psychological reactance process. Finally, other ad formats (TV, radio, Internet, etc) can be used to check if they really trigger smokers' psychological reactance. Future research focusing on these patterns may narrow this gap.

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APPENDIX: THE MEASUREMENT SCALES

- ***Psychological reactance*** **(Hong and Faedda, 1996)**

1. "The message makes me irritated,"
2. "The message makes me annoyed,"
3. "This message triggers a sense of resistance,"
4. "This message induces me to feel doing the opposite."

- **Perceived threat to freedom (Dillard and Shen, 2005)**

1. "The message threatened my freedom to choose,"
2. "The message tried to make a decision form,"
3. "The message tried to manipulate me,"
4. "The message tried to pressure me."

- ***Trait reactance proneness*** **(Hong and Faedda, 1996)**

1. "When someone tells me what to do, I feel like doing precisely the opposite";
2. "Rules and regulations provoke some kind of resistance in me";
3. "When somebody tells me not to do something, I react by thinking that is exactly what I want to do";
4. "I react negatively when others try to tell me what to do."

- ***Perceived loss of control*** **[Therapeutic Reactance Scale (Dowd et al, 1991)]**

1. "I resent authority figures who try to tell me what to do".
2. "I have a strong desire to maintain my personal freedom".
3. "Nothing turns me on as much as a good argument".
4. "If I am told what to do, I often do the opposite".
5. "I am sometimes afraid to disagree with others".
6. "I don't mind other people telling me what to do".
7. "I am not very tolerant of others' attempts to persuade me".
8. "I often follow the suggestions of others".
9. "It is important to me to be in a powerful position relative to others".
10. "I am very open to solutions to my problems from others".
11. "I consider myself more competitive than cooperative".
12. "I usually go along with others' advice".

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Living with Difference: Experiences of Adolescents Subjected To Oral Facial Cleft Repair

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ABSTRACT

Adolescents are best understood in a developmental context. The normal tasks of adolescent become complicated for the child with oral facial clefts. Existing multi specialty care is primarily aimed at physical rehabilitation with the psychological issues of care often being neglected. These articles address the biopsychosocial problems of adolescents with oral facial clefts who is experiencing adjustment problems. These articles also stress the need of a biopsychosocial intervention package for adolescence to assist in mastering the age appropriate developmental task.

Keywords: *Adolescence ; Oral facial clefts ; Biopsychosocial intervention package.*

Developmental tasks of adolescence can be broadly characterized as the evolution of a sense of personal identity and the achievement of independence. (Erikson,1963)The normal developmental tasks of adolescents include individuation from family development of sense of personal identity establishment of satisfactory peer relationship and body image.[1] Research shows learning to live with a change in appearance of one's face as a result of injury/disease is a difficult tasks.[2] The role of physical appearance has proved that a healthy physical appearance, regardless of facial or physical characteristics is considered attractive. Significant literature has shown in addition to coping with their physical appearance, adolescents with cleft anomaly in general have to deal with their more superficial psychological issues/psychological limitations.[3] Thus this paper discuss about the various biopsychosocial issues among adolescents with oral facial clefts.

Statement of the Problem

A research critique on lived in experience of adolescents subjected to oral facial cleft repair, at Charles Pinto Centre, Jubilee Mission Medical College, Thrissur.

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*Responding Author

OBJECTIVES

- Elicit the lived in experiences of adolescents before oral facial cleft repair
- Explore the lived in experiences of adolescents subjected to after oral facial cleft repair
- Extrapolate the various dimensions of the lived in experiences of adolescents subjected to oral facial cleft repair

Purpose

Develop an appropriate Biopsychosocial Intervention Package on Coping strategies for the adolescents subjected to Oral facial cleft repair

Operational Definition

Adolescents: Both the female and male adolescents in the age group of 12-21 years.
Lived in experience: Description on feeling and perception before and after the oral facial repair as verbalized by the adolescents
Oral facial cleft repair: Staged repair for the congenital anomaly of the face which includes cleft lip only, cleft palate only and cleft lip and palate

Conceptual Framework

Conceptual framework for the study was modified Peplau's interpersonal relation model.

METHODOLOGY

Design: Qualitative design with phenomenological approach
Setting: Charles Pinto Center at Jubilee Mission Medical College, Thrissur
Sample and sampling technique: Convenient sample of 20 adolescents admitted for Oral facial cleft repair.

Sampling Criteria

Inclusion criteria:

- Both the male and female adolescents within the age group of 12 to 20 years
- Adolescents who are able to speak and understand Malayalam

Exclusion criteria:

- Adolescents who are not willing to participate
- Adolescents who have Pierre Robin Syndrome

Instruments

A) Demographic data
B) Interview schedule with open ended questions

Data Collection

After obtaining permission from the concerned authority, the procedure for data collection was explained to the study participants. The informed consent was obtained from the samples to audiotape the interview. An in depth interview was conducted using an unstructured questionaire

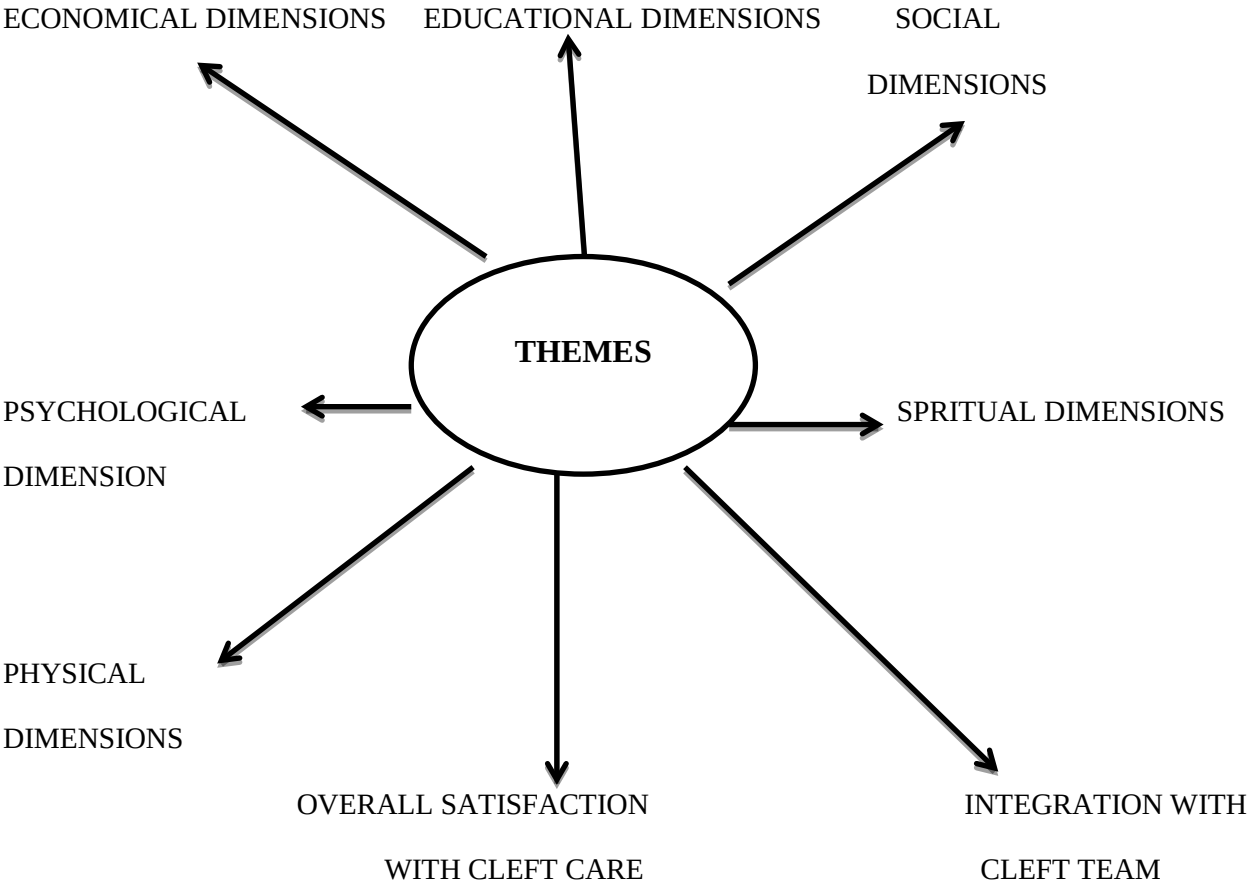
Data Analysis

Taped interview dialogue were listened to and transcribed in to verbatim. Thematic content analysis was done by Colaizzis analysis

Modified Colaizzi Analysis Framework: -

- The transcripts were converted in to formulated statements.
- Significant statement and phrases pertaining to the experience of patients under investigation were extracted
- Meanings of formulated statement and themes were identified
- Significant statements were organized in to clusters of themes
- The themes were used for exhaustive description

Organisation of Findings / Transcribed Verbatim



1. PHYSICAL DIMENSIONS

Preoperative experience

- " As I am worrying about my physical appearance I could not get sleep"

- "I feel that I am unfit to achieve goal in my life due to this defect. So I am not able to sleep properly".
- " I am not able to take non vegetarian items especially (chicken) which I like most , due to the braces over the teeth
- "I will smile but I always wonder,oh, I have an ugly smile?

Post-operative experience

- " I am unable to sleep always due to throbbing pain"
- "I felt very difficult because I was always lying in the bed"
- " I was shocked when I recovered from anesthesia by seeing a tube in the nose , nasal package which totally covered my nose"
- Many times I shouted and screamed towards to my mother , because she only compelled me to undergo this last stage of surgery"
- I felt very tired, because I was advised to take only liquid diet".

2. PSYCHOLOGICAL DIMENSIONS

Preoperative experience

- "It is hard to explain because a lot of times, I don't care what people say about me"
- "I am always worried about my look and stuff. But then again, I don't really care what people think of me as long as t am comfortable with who I am"
- "I am giving burden to my parents. In order to take me for therapy consultation , they have to take leave from job which causes financial constraints"
- I was so upset about my appearance. If my face comes to "normal" as like you. I can boldly look and talk to my friends.

Post operative experience

- When I think that I am going to get normal face, nose and lips I feel I am the luckiest person in this world
- Now I am praying to god, let this surgery be the last surgery on my face
- "I have seen another boy in the OPD in my same age who undergone the same surgery , But even after the surgery also his speech was not normal"

3. ECONOMICAL DIMENSIONS

Preoperative experience

- "If I attend the speech therapy regularly (daily 1st week)once in a week followed by this we will get the bus fare expenses from Charles Pinto Center"
- "My parents are very poor. They are spending lot of money towards to my treatment"
- Now I am 20 year old. My father expired at the age of 4 year. From my birth onwards my mother and grandmother is taking me to this hospital for consultation to correct my defect. This is my last stage of surgery. Oh! God ……"

Post operative experience

- I will go for job after my studies and I will support my father

4. EDUCATIONAL DIMENSIONS

Preoperative experiences

- "I stopped by school education at upper primary level , because I was always teased by my friends"
- My teacher has provided emotional back up always which helped me to overcome the situations
- "I was good in singing. Ilike singing too but due to defect in speech I was excluded from the group song ; stating my sound is unique"
- "Now I am happy even though all my stages of surgery is over I know I have to come for regular follow up till my speech get clear"

5. SOCIAL DIMENSIONS

- "There are people in my school who don't like me because I have a cleft lip and palate god knows why , I don't know"
- Constant starring and teasing lowered it (self-esteem) quite a bit …. Then it takes a while to bring it back up to know that you are not supposed to care what other people think
- "People will talk to you more when you look beautiful"
- "The facial difference , I guess it's made me more of a shy person , holding myself back from really getting to know people"
- "I always wonder what my life would be like if I was normal. But I don't know I have to live with it so you might as well enjoy yourself"
- "I talk about my surgery with friends and with this surgery coming up , they want to come and visit me"
- "After surgery I will be more outgoing and that kind of things ; yeah I will be much more confident"
- "I found my group of friends and they stood up for me"
- I don't really care what people think because I have my loving family

6. SPIRITUAL DIMENSIONS

Preoperative experience

- "I don't know why god has created me like this"
- "While coming for each stage of surgery my parents will have offerings to god"
- "I am praying to god daily , let my speech be clear , and let me able to talk loudly as like others"
- "I don't believe in worshiping god"

Post operative experience

- "By god's grace only all my stages of surgery came into success. After a one week of rest of vocal cord; I will be normal. I should be more thankful to god"

7. INTERACTION WITH CLEFT TEAM

- "I am very much satisfied with the cleft team"
- "Many times inconvenience of long journey to clinics overshadowed the purpose of appointment"

- "I am getting discharge today after my last stage of surgery. Today cleft team has shown all my previous photographs with obvious facial defect. Even my parents don't have all the photographs of mine before the surgery. Thank to cleft team"
- "The effort by the speech therapist is highly appreciate"
- "The consoling words by the plastic surgeons and counseling session, homework by the speech therapist, orthodontic care, everything is standard and appreciable".

8. OVERALL SATISFACTION WITH CLEFT CARE

- "Here the doctors and sisters supported me and my family very well, which helps me to reduce my fear."
- "Today doctor came for rounds. He removed the dressing over my nose, I was little panic at that time you know! Finally he asked a mirror from my mother and he asked to look at my face in the mirror." Oh! God I was surprised to see my new nose. He said now "you look so beautiful."

The subthemes extracted from the themes before and after oral facial cleft repair were as follows:

THEMES	SUBTHEMES	
	Pre-operative experience	**Post-operative experience**
Physical dimension	• Sleep disturbance • Physical appearance • Not able to take diet properly	• Pain • Sleep disturbance • Difficult in ADL • Fatigue
Psychological dimension	• Anxiety about the appearance • Guilty feeling • Anxiety about the outcome of surgery	• Happiness • Fear about the outcome of surgery
Economical dimension	Economical burden	Wish to earn money as early as possible
Educational dimension	• Discontinued from studies due to this defect • Knowledge about follow up	
Social dimension	• Peer support • Family support • Inability to meet other	
Spiritual dimension	• Blaming God • Praying to God	Thankful to God
Interaction with cleft team	• Much satisfied • Long journey to reach to clinic • Emotional support	
Overall satisfaction with cleft care	Satisfactory	

DISCUSSION

In this study 20 interviews were carried out among adolescents subjected to oral facial cleft repair. There were 2 broad aims to this study.

Totally 8 themes were identified in the analysis such as physical dimensions, psychological dimensions, economical, educational, social, spiritual, interaction with cleft team and overall satisfaction with client care. Body image disturbances, sleep disturbance, pain in the post operative period, feeling fatigue were the physical discomfort experienced by the samples, whereas 2 subjects did not experience sleep disturbances. Although adolescents seem relatively satisfied with their body image, some features specifically associated with oral facial clefts such as nose and teeth are considered less than satisfactory and may result in problems with body image. Few adolescents are dissatisfied with their speech. However, those with concerns regarding facial appearance are also more likely to have concerns regarding speech. Social isolation from peers, due to poor speech was obviously identified. During interviews one of the mother of a 15 year old adolescent reported that her child is 'shy' although she is unsure whether this was due to 'cleft', or just a teenage phase. During the interview, investigator identified adolescents and their parents invest a great deal of emotional and physical effort in to their child's cleft care. The passage of time, coupled with current expressions of satisfaction, may mask the painful feelings associated with past experiences. Emotional needs of these adolescents should be taken care in order to promote coping strategies. The investigator was able to find out that each adolescent is unique and experience and perception varies from adolescent to adolescent. Nurses as health professionals needs to intensify their involvement in implementing the care to enhance the supportive environment and to reduce the stress of adolescents with oral facial cleft before and after surgery.

CONCLUSION

The study was conducted to explore the lived in experience of adolescents subjected to oral facial cleft repair has been carried out using interview schedule.

- Despite high level of expressed satisfaction for clinical outcome, majority of subjects perceived self confidence had been very much affected as a result of their cleft.
- This qualitative study demonstrated a clear need for a biopsychological assessment to be routinely incorporated into existing cleft care programmes.
- This assessment would specifically identify individuals for whom counseling or social skills training would be of benefit.
- The rehabilitation of oral facial cleft adolescents should address psychological outcome as well as clinical outcome.

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Big Five Personality Factors as Predictors of Organizational Citizenship Behavior: A Complex Interplay

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ABSTRACT

The present study investigated the Big Five personality factors as predictors of citizenship behaviors directed towards individuals (OCBI) and towards the organization (OCBO). The Big Five Inventory by Donahue & Kentle (1991) and Organizational Citizenship Behavior Scale by Lee and Allen (2002) were used and the sample comprised of 325 clerical employees, from nationalized and co-operative banks in Maharashtra. Findings revealed that openness emerged as the strongest predictor of both OCBI and OCBO, followed by extraversion. Moreover, openness fully mediated the relationship between agreeableness and OCBI, whereas extraversion partially mediated the relationship between agreeableness and OCBI. Openness and extraversion also partially mediated the relationship between conscientiousness and OCBO.

Keywords: *Big Five personality factors, OCBI, OCBO, mediation.*

Barnard (1938) proposed that an organization that has employees who are willing to put cooperative efforts, essentially achieves its objectives effectively. This idea of cooperative efforts was further extended as extra-role behavior by Katz and Kahn (1966, 1978). Extending the idea of extra-role behavior from the work of Katz and Kahn, Organ and colleagues coined the term "organizational citizenship behavior" (OCB) (Bateman & Organ, 1983; Organ, 1988). Organ (1988) defined organizational citizenship behaviors as behaviors of individual employees that are discretionary in nature, that are not directly or explicitly recognized within the framework of the formal reward system, and that consequently promote the effective functioning of the organization. In general, OCB has been linked positively to reductions in costs, improvements in efficiency, profitability, production quantity and customer satisfaction (Dunlop & Lee, 2004; Koys, 2001; Podsakoff & MacKenzie, 1994; Walz & Niehoff, 1996, Yen & Niehoff, 2004), and negatively to intentions to leave the organization and actual departures (Chen, 2005; Mossholder et al., 2005). However, factor analytical studies by Williams and

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Anderson (1991) show that OCB should be defined by its target. Their two-factor model of OCB thus differentiates between citizenship behaviors aimed at individuals / colleagues (OCBI), and those directed at the organization (OCBO) (Williams & Anderson, 1991).

Among antecedents of OCB, employee personality has been the most prominently researched predictors of OCB (Bateman & Organ, 1983; Organ, 1988; Smith et al., 1983). Findings of meta-analyses by Podsakoff et al. (2000), and Borman et al. (2001) revealed that conscientiousness emerged as the strongest predictor of OCB. Agreeableness too was found to predict OCB in three meta-analyses (Borman et al., 2001; Chiaburu et al., 2011; and Podsakoff, MacKenzie, Paine, & Bachrach, 2000), whereas negative affectivity received support as a weak but valid predictor of OCB in some instances. Openness and extraversion were not considered in the three meta-analyses discussed earlier (Borman et al., 2001; Organ & Ryan, 1995; Podsakoff et al., 2000). However, a fairly recent meta-analysis by Chiaburu et al. (2011) demonstrated openness as the strongest predictor of OCB, whereas extraversion emerged as the second best predictor of OCB after conscientiousness. In all these meta-analyses and in most other related studies, however, focus has predominantly been placed upon the five-factor model of OCB proposed by Organ (1988) that includes altruism, conscientiousness, sportsmanship, courtesy and civic virtue, whereas the two-factor model of OCB by Williams and Anderson (1991) has received little attention, and even more so in the Indian setup. According to Williams and Anderson (1991) behaviors included in OCBI may be equated to the dimension referred to as altruism in earlier literature (Organ, 1988). OCBO on the other hand may be equated to the dimension referred to as generalized compliance in earlier literature (Smith et al., 1983), as organizational obedience by Graham (1991), and as organizational compliance by Podsakoff et al. (2000). While agreeableness is associated with high levels of interpersonal competence (Witt et al., 2002) and effective collaboration in situations demanding joint action (Mount et al., 1998), conscientiousness reflects efficiency, organization, reliability, and thoroughness. This combined with the existing literature available on Organ's model of OCB, suggests that agreeableness can be expected to be the strongest predictor of OCBI, whereas conscientiousness can be expected to be the strongest predictor of OCBO. The present study thus investigated the role of personality factors as predictors of OCBI and OCBO.

Hypotheses

H_1: Conscientiousness, agreeableness, openness to experience, and extraversion are positively correlated with OCBI and OCBO.

H_2: Neuroticism is negatively correlated with OCBI and OCBO.

H_3: Agreeableness is the strongest predictor of OCBI.

H_4: Conscientiousness is the strongest predictor of OCBO.

METHOD

Sample

Convenience sampling technique was used for the present study. Of the 550 distributed questionnaires, 399 questionnaires were received. After screening out incomplete questionnaires and questionnaires with inconsistent/casual response patterns, data of 325 employees (166 males and 159 females, Mean age – 43.26) across 11 nationalized and 9 co-operative banks, covering over 90 branches in Maharashtra, was retained for the final analysis.

Tools

All respondents were given a compiled questionnaire beginning with section for demographic details, general instructions, informed consent and then the tools, comprising of the 44 item Big Five Inventory (BFI) (John, Donahue & Kentle, 1991) which measures the five factors of personality – neuroticism, extraversion, openness, agreeableness, and conscientiousness; and the16 item Organizational Citizenship Behavior Scale developed by Lee & Allen (2002) which has 8 items each for individual-directed (OCBI) and organization-directed (OCBO) citizenship behaviors. High scores on subscales of BFI indicate a high tendency with respect to that personality trait. The reliability coefficients range from .79 for agreeableness to .88 for extraversion, with a mean coefficient of .83. A high score on OCBI and OCBO indicates a high frequency of demonstrating citizenship behaviors. Authors report alpha coefficient values .87 and .89 for OCBI and OCBO scales respectively.

Statistical Analyses

The data was tested for adherence to assumptions of sample size adequacy, linearity, collinearity, and independence of errors (Garson, 2012; Williams et al., 2013). Pearson's Product-moment correlation and regression analyses were performed using SPSS Ver. 22. Path analysis testing mediation was performed using Smart PLSVer. 3.2.1 (Ringle et al., 2015) and then Sobel test was performed using Daniel Soper's online statistical calculator.

RESULTS AND DISCUSSION

Table 1 Summary of Person's Product-Moment Correlation Coefficients between the Personality Dimensions and OCBI and OCBO (n = 325)

	Conscientiousness	Agreeableness	Extraversion	Openness	Neuroticism
OCBI	.202**	.175**	.252**	.361**	-.053 (NS)
OCBO	.275**	.245**	.318**	.432**	-.108 (NS)

** = $p < .01$ NS = not significant ($p > .05$)

As seen in Table 1, conscientiousness, agreeableness, openness to experience and extraversion were found to be correlated with both OCBI and OCBO. Thus hypotheses 1 was supported. Hypothesis 2, however, was not supported, as neuroticism was not found to be significantly correlated with either OCBI or OCBO.

Earlier studies have upheld conscientiousness and agreeableness as the most prominent antecedents of OCB (e.g. Hurtz & Donovan, 2000; Ilies et al., 2009; Organ & Ryan, 1995). Multiple regression analysis was performed to test hypotheses 3 and 4, excluding the insignificantly correlated neuroticism.

Table 2 Summary of Multiple-Regression Analysis for the Personality Dimensions and OCBI (n = 325)

			ANOVA	Coefficients			
Predictor	**R**	**R^2**	**F**	**B**	**β**	***t***	**Sig.**
Conscientiousness	.387	.150	14.127**	.150	.016	0.256	.789
Agreeableness				.606	.069	1.160	.247
Extraversion				.988	.122	2.152	.032
Openness				2.769	.288	4.799	.000

** = $p < .01$

As seen in Table 2, against expectations however, openness to experience emerged as the strongest predictor of OCBI, followed by extraversion. Thus hypothesis 3 was not supported.

Table 3 Summary of Multiple-Regression Analysis for the Personality Dimensions and OCBO (n = 325)

			ANOVA	Coefficients			
Predictor	**R**	**R^2**	**F**	**B**	**β**	***t***	**Sig.**
Conscientiousness	.478	.229	23.716**	.350	.046	0.773	.440
Agreeableness				.779	.109	1.931	.054
Extraversion				1.045	.159	2.949	.003
Openness				2.500	.321	5.612	.000

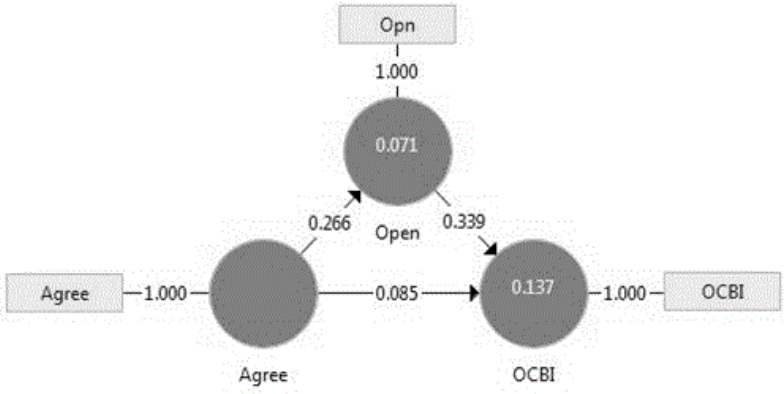
** = $p < .01$

With respect to OCBO too, Table 3 shows that openness to experience emerged as the strongest predictor, followed by extraversion. Thus hypothesis 4 was not supported either.

The explanation for these findings can be drawn from the study by King et al. (2005), which put forth the complex interplay within the personality traits, suggesting that single traits as predictors give an incomplete picture of their relationship with the outcome variables. More specifically, they argued that though agreeableness and conscientiousness may be necessary predictors of helping behaviors, any single trait cannot possess sufficient explanatory power, as interpersonal helping emerges from the motive to volunteer to help other people and the motive to engage in discretionary behaviors for the good of the organization (Hough, 1992; Organ, 1997).

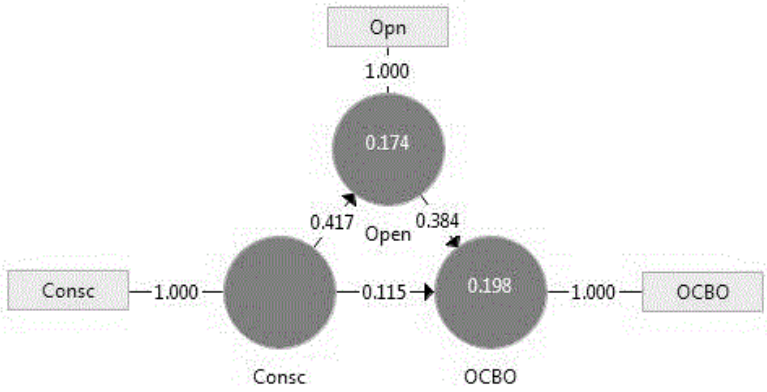
Though a mediator is often a person's psychological process in response to a stimulus (Hoyle & Robinson, 2003), the personality factors of extraversion and openness to experience could reflect the motivational aspects mediating the relationship between conscientiousness and agreeableness on one hand, and OCB on the other. Thus path analysis testing for mediation was performed using the Baron and Kenny approach (Baron & Kenny, 1986) with the help of Smart PLS. Bias-corrected and accelerated (BCa) bootstrapping was run using a subsample of 5,000. The I.V. to mediator and mediator to D.V. Beta values, and their standard error values were then entered in the Daniel Soper online calculator for performing Sobel test.

Figure 1 Path Diagram for the Mediation Effect of Openness to Experience in the Relationship between Agreeableness and OCBI



In Step 1 of the first mediation model tested, the regression of OCBI (D.V.) on agreeableness (I.V.), ignoring openness (the mediator), was not significant, $b = 0.09$, $t = 1.46$, $p > .05$. However, following Rucker et al. (2011), further mediation analysis was performed irrespective of lack of adherence to the requirement of significance of relationship between the I.V. (agreeableness) and D.V. (OCBI). Step 2 showed that the regression of openness on agreeableness was significant ($b = 0.27$, $t = 5.20$, $p < .01$). Step 3 of the mediation process showed that the regression of OCBI on openness, controlling for agreeableness, was significant ($b = 0.34$, $t = 5.83$, $p < .01$). Step 4 of the analyses revealed that controlling for openness rendered the direct effect of agreeableness on OCBI insignificant ($t = 1.46$). Sobel test statistics ($z = 3.89$, $p < .01$) confirmed that openness fully mediated the relationship between agreeableness and OCBI.

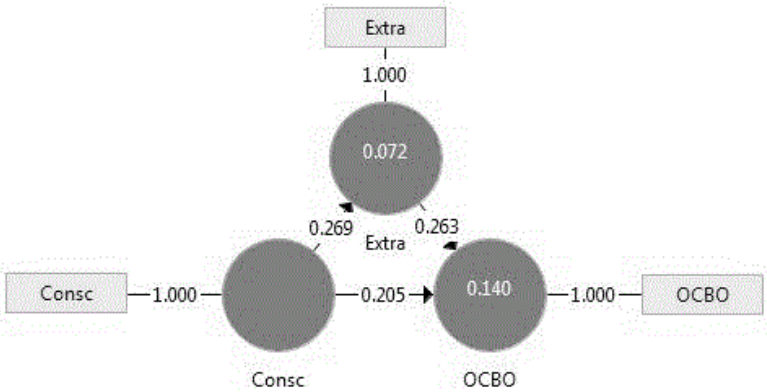
Figure 2 Path Diagram for the Mediation Effect of Extraversion in the Relationship between Agreeableness and OCBI



In Step 1 of the second mediation model tested, the regression of OCBI (D.V.) on agreeableness (I.V.), ignoring extraversion (the mediator), was significant, $b = 0.13$, $t = 2.44$, $p < .05$. Step 2 showed that the regression of extraversion on agreeableness too was significant ($b = 0.18$, $t = 3.46$, $p < .01$). Step 3 of the mediation process showed that the regression of OCBI on extraversion, controlling for agreeableness, was significant ($b = 0.23$, $t = 3.96$, $p < .01$). Step 4 of the analyses revealed that even after controlling for extraversion, the direct effect of agreeableness on OCBI remained significant ($t = 2.44$). Sobel test statistics ($z = 2.07$, $p < .05$) too confirmed that extraversion partially mediated the relationship between agreeableness and OCBI.

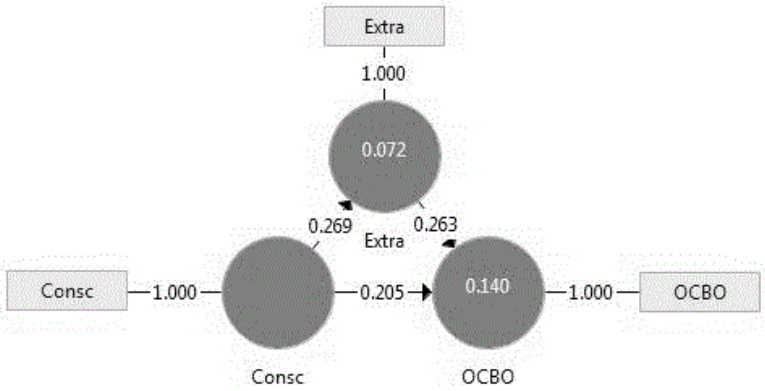
Agreeableness encompasses a pro-social and communal orientation (John & Srivastava, 1999) suggesting that highly agreeable employees would be more likely to engage in helping behaviors at the workplace, than individuals low on this trait. On the other hand, individuals high on extraversion are enthusiastic while engaging in the social world, are proactive, and tend to view others positively (John & Srivastava, 1999). The findings of the study imply that employees, who are high on agreeableness but low on extraversion, may be reluctant to initiate social interactions spontaneously to help others.

Figure 3 Path Diagram for the Mediation Effect of Openness to Experience in the Relationship between Conscientiousness and OCBO



In the third mediation model tested, step 1 showed that the regression of OCBO (D.V.) on conscientiousness (I.V.), ignoring openness to experience (the mediator), was significant, b = 0.12, t = 1.99, p < .05. Step 2 showed that the regression of openness on conscientiousness was also significant (b = 0.42, t = 8.79, p < .01). Step 3 showed that the regression of OCBO on openness, controlling for conscientiousness, was significant (b = 0.38, t = 6.47, p < .01). Step 4 of the analyses revealed that the direct effect of conscientiousness on OCBO remained significant (t = 1.99), even after controlling for openness. Sobel test statistics (z = 5.25, p < .01) too confirmed that openness partially mediated the relationship between conscientiousness and OCBO.

Figure 4 Path Diagram for the Mediation Effect of Extraversion in the Relationship between Conscientiousness and OCBO



In the fourth mediation model tested, step 1 showed that the regression of OCBO (D.V.) on conscientiousness (I.V.), ignoring extraversion (the mediator), was significant, b = 0.21, t = 3.71, p < .01. In step 2 the regression of extraversion on conscientiousness was found to be significant too (b = 0.27, t = 5.78, p < .01). Step 3 revealed that the regression of OCBO on extraversion, controlling for conscientiousness, was significant (b = 0.26, t = 5.04, p < .01). Step 4 of the analyses revealed that the direct effect of conscientiousness on OCBO remained significant (t = 3.71), even after controlling for extraversion. Sobel test statistics (z = 3.00, p < .01) confirmed that extraversion partially mediated the relationship between conscientiousness and OCBO.

The findings suggest that individuals scoring high on conscientiousness will be diligent, responsible, and dedicated and thus more likely to demonstrate OCBO; however, the motive required to voluntarily engage in behaviors in favor of the organization, may be reflected through the personality disposition of openness to experience. Similarly, a highly conscientious employee who is introverted may be reluctant to initiate citizenship behaviors directed towards the organization. To extent to which a highly conscientious employee also possess a positive interpersonal orientation, may better predict OCBO.

CONCLUSIONS

Based upon the findings of the present study, the following conclusions may be drawn -

1. Conscientiousness, agreeableness, openness to experience and extraversion are positively correlated with both OCBI and OCBO.
2. Openness to experience is the strongest predictor of both OCBI and OCBO.
3. Openness to experience fully mediates the relationship between agreeableness and OCBI.
4. Extraversion partially mediates the relationship between agreeableness and OCBI.
5. Openness to experience partially mediates the relationship between conscientiousness and OCBO
6. Extraversion partially mediates the relationship between conscientiousness and OCBO.

THEORETICAL AND PRACTICAL IMPLICATIONS

There exists a plethora of studies linking dispositions and citizenship behaviors; however, attempts to study OCB beyond Organ's conceptualization have been only modest. Moreover, studies have generally focused on single traits as predictors of outcomes. However, given that personality is composed of multiple traits, and in the light of the findings of the present study, further studies in this area may consider how traits may work together to influence OCB. The present study has implications for personality theorists and researchers, as well as for HR personnel, considering the growing concern of rising turnover rates. The findings of the present study bring about the importance of the personality dimensions, especially openness to experience and extraversion, as predictors of OCBI and OCBO, as well as significant mediators. The interplay of personality traits within an employee must be taken into account, rather than looking at traits as mutually exclusive predictors of organizational outcome behaviors. Theorists may consider development of combination models with different permutations and combinations of the Big Five traits (e.g. low extraversion – high openness, high extraversion – high openness, and so on). Organizations may consider these findings at the selection stage, as well at the stage of planning of citizenship-based training programs.

LIMITATIONS AND FUTURE DIRECTIONS

Considering the total number of bank clerical employees in India, the sample for the present study, though sufficient as per the various rules of thumb, is very small. To be in a position to generalize the findings of the study on a pan-India basis with a significant amount of confidence, a larger sample from other states too must be studied. Secondly, the size of branches in terms of staff strength selected for data collection was controlled for, but the amount of workload could not be quantitatively controlled for. Opportunities to exhibit OCB could change as a function of the magnitude of workload at the branch. The data collected emerges from self-report inventories, and thus the honesty of the responses given in terms of indulgence in citizenship acts may be questioned.

Taking into account the findings and limitations of the present study, further investigation to establish the nature of the obtained findings may be suggested. Firstly, the approach of

investigating mediating effects of personality factors between other personality dimensions and outcome behaviors, may open a new avenue of research approach. Moreover, the approach may be extended to other workplace outcome behaviors and even in non-industrial setups (e.g. for predicting social behaviors in social psychology, for determining prognosis and psychotherapies in counseling and clinical psychology, in studies in experimental and cognitive psychology, and so on). The interplay of other demographic factors like gender and age, in combination with the dispositional factors may be studied as well.

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APPENDIX

Correlation Matrix for all variables (n = 325)

	Mean	SD	Conscientiousness	Agreeableness	Extraversion	Openness	Neuroticism
Conscientiousness	4.12	0.57	1				
Agreeableness	4.06	0.60	.483**	1			
Extraversion	3.33	0.65	.269**	.180*	1		
Openness	3.84	0.55	.417**	.266**	.395**	1	
Neuroticism	2.68	0.70	-.401**	-.272**	.234**	-.231**	1

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Lived Experience of Patients Undergoing Hemodialysis: Quality of Life Perspective

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ABSTRACT

There is growing recognition of Health-Related Quality of Life (HRQOL) issues in End Stage Renal Disease (ESRD) patients undergoing Hemodialysis (HD). The aim of the present study was to explore the lived experience of Quality of Life (QOL) among patients undergoing Hemodialysis. The study involved a qualitative approach that used an interpretive hermeneutic phenomenology based on Van Manen's method. The sample included seven patients undergoing Hemodialysis in two selected hospitals at Ernakulam district in Kerala. They were recruited by purposive sampling. Data were collected using semi-structured interviews. The thematic analysis followed the six steps delineated by Max Van Manen and four themes emerged. They were crestfallen life (3 sub themes; hard pressed life, deserted life and abounding losses); support and comfort; accompanying death and unfulfilled wishes. The findings shed light on the lived experience of QOL that has not yet been researched in an Indian scenario. The generated knowledge can be used by health professionals including nurses to help patients undergoing HD lead a life with better quality of life.

Keywords: *Lived Experience, Quality of life, End Stage Renal Disease, Hemodialysis.*

Chronic kidney disease (CKD) is a common on-communicable disease that is becoming a worldwide health problem. CKD is a gradual and permanent loss of kidney function. Generally, renal diseases progress to a final stage as End Stage Renal Disease and the function is substituted by Renal Replacement Therapy (RRT), Hemodialysis, Peritoneal Dialysis or transplantation (Jamison etal, 2006). Hemodialysis continues to be the most common mode of therapy worldwide, evidenced by data showing that, in over 70 percent of reporting countries, at least 80 percent of patients are on this mode of therapy(Zhang &Rothenbacher 2008).

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Health-related QOL is an important measure of how a disease affects the lives of patients. Patients who are treated with dialysis experience many threats to Health Related Quality of Life, both from the myriad symptoms of ESRD itself and from the physical and mental burden of dialysis treatment (Jaar, Chang, & Plantinga, 2013). World Health Organization (WHO) has defined Quality of Life as 'an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (Jaar, Chang, & Plantinga, 2013).

There is increasing awareness in the literature that patients undergoing HD live a poor QOL. Many studies report that ESRD patients on HD have poor HRQOL when compared with the general population (Jaar, Chang, & Plantinga, 2013; Yusop, Mun, Shariff, &Huat, 2013;Feroze,Noori, Kovesdy, Molnar & Martin, 2011).Though there are quite a large number of studies describing the frequency, percentage and the mean QOL score which translate patients' subjective experiences into objectively quantifiable data, there are only few qualitative studies that have examined the experiences of these patients' life situation.

A systematic review and thematic synthesis was conducted to synthesize published qualitative studies of patients' experiences, beliefs, and attitudes about Peritoneal Dialysis by using Databases (MEDLINE, Embase, PsycINFO, and CINAHL), theses, and reference lists searched up to November 2011 (Tong, Lesmana, Johnson, Campbell & Craig, 2013). The results revealed 7 themes: resilience and confidence, support structures, overwhelming responsibility, control, freedom, sick identity and disablement.

There was only one Indian study that used a phenomenological research design (using Husserl's Method) to explore the lived experience among 10 persons undergoing haemodialysis from the dialysis unit of Kasturba Hospital, India (Valsaraj, Bhat, Prabhu & Dinesh, 2014). The themes emerged at the end of the study were mental agony, physical limitations, coping, financial burden, lack of support, feelings towards the machine and dialysis, search for hope and betterment, spiritual coping, marital relationship and sexuality and uncertainty and fear of tomorrow.

There is no published qualitative study found by the researcher that has examined the lived experience of QOL among patients undergoing HD. But it is important to develop a deeper understanding of this phenomenon, because from a better understanding of the experience among people living on dialysis, health professionals can more adequately support them.So the researcher chose to do a qualitative approach using Van Manen's approach to understand their lived experiences which will provide a valuable insight about the patient's world related to QOL.

The present investigation differs from other qualitative investigations because it tries to explore the lived experience of quality of life that has not researched so far especially in India. This research will add to the body of research on and may generate ideas for intervention research.

OBJECTIVE

The objective of the study was to

1. explore the lived experience of QOL among patients undergoing Hemodialysis

METHODS

Research Design and Sampling

The study involved a qualitative approach that used an interpretive hermeneutic phenomenology based on Van Manen's method. The sample was seven patients undergoing Hemodialysis, selected purposively from two selected hospitals (Regional Dialysis centre, Aluva and Lourdes Hospital) of Ernakulam district in Kerala. Sample size was seven, as this was the number at which 'saturation' of the data was reached. As the purposive sampling was conducted for the purpose of diversifying the participants, it was called a maximum variation sampling technique. Criteria of sample selection were patients who were undergoing hemodialysis more than 3 months; undergoing dialysis twice a week; age above 18years;and who were without active medical or psychiatric conditions.

Instrument

1. Personal information

The first section involved a series of questions obtaining information about the participant's age, gender, educational background, marital status, type of family, duration since diagnosis of chronic renal failure, duration since undergoing hemodialysis, last hemoglobin value, and co morbidities.

2. Interview guide

A semi-structured interview guide was developed based on the literature review and was sent to experts and modifications were done as per to the expert opinions. It had the main question as: Tell me about your thoughts and feelings about your Quality of life while undergoing Hemodialysis? Subsequent questions that focused on spatiality, corporeality, temporality, and relationality were included. Probes were offered as a means to clarify participant descriptions.

Ethical consideration

Ethical clearance was obtained from the institutional ethics committee. Informed consent was obtained from the participants. Confidentiality and anonymity was assured. As the information sought was of a personal nature, there was a possible risk of participant distress, in recalling an unpleasant event, for example. Every effort was made to ensure that the participants were not put at risk of emotional harm and they were assured that they could cease the interview at any time. As a health professional the investigator was skilled in monitoring and assessing patient responses and therefore was competent to recognise and respond to any distress that may have been exhibited by a participant. No such situation arose during data collection. Pseudonyms were created to ensure confidentiality.

Data collection

The study was conducted from June 2014 – September 2014. Subjects who were willing to participate in the study was assessed for eligibility as per to inclusion criteria. After obtaining permission from the hospital authorities, data were collected from seven patients undergoing hemodialysis, using a semi structured interview guide. The place for interview was decided based on the comfort expressed by the study participants. All the interviews were conducted while the patients were undergoing hemodialysis. The researcher gathered experiential description through face-to-face interviews. Participants were encouraged to elaborate on their responses to some questions and to further expand and clarify these responses. The researcher listened and observed the participants closely, noted their body language and tone of voice. The researcher was respectful of silences as it would allow the participant to generate meaning and new understanding. The average time taken for each interview was approximately15-20 minutes. Each interview was audio taped and later transcribed for data analysis. Information about demographics was collected at the end of the interview. Data collection was stopped when data saturation occurred with seven study participants, i.e., data was collected until no new information emerged.

Statistical Analysis

The data were analyzed manually using interpretive phenomenology. The thematic analysis followed the six steps delineated by Max Van Manen. In order to attribute meaning to the data, van Manen suggests three methods (the detailed reading approach, the selective or highlighting approach and the holistic reading approach) for isolating thematic statements. All three approaches were employed during the data analysis of this research. The early analysis involved analyzing each interview separately or going from the parts (of the text) to whole (Manen, 1990).Highlighting of keywords, phrases and ideas were done. Keywords became concepts through intuitive ideas and reading and re-reading the data, dwelling with the data and dialoguing with the text (Manen, 1990).The concepts from the preliminary analysis were then grouped in an additional column of the table, pooled with similar concepts after much thought on which ideas belonged together, to form the subthemes and finally the development of major themes. Hermeneutic phenomenological reduction was used for qualitative analysis (Manen, 1990). In Hermeneutic reduction (Adams and Manen 2008), researchers reflect on their pre-understanding, framework and biases. They also search for genuine openness to engage in a conversational relation with phenomena. To achieve this reduction and critical self- awareness, a journal of personal reflections on the interview as well as researcher's thoughts throughout the study period was kept that has been of value in interpretation and discussion of participant's data.

RESULTS

I. Description of the pertinent characteristics of the participants

The participant's age ranged from 39 to 62 yrs. Four were males. Majority had secondary education. All participants were married and were unemployed. Five of them belonged to nuclear family. The years since diagnosis of ESRD ranged from 3 to 7 years. The years since undergoing

Hemodialysis ranged from 1 year to 6 yrs. The Hb value ranged from 6.5 to 11.2gms/dL. Hypertension and diabetes mellitus were the major co-morbidities.

II. Themes derived from the lived experience of QOL among patients undergoing HD

The themes that emerged were crestfallen life (hard pressed life, deserted life and abounding losses), support and comfort, accompanying death and unfulfilled yearning wishes.

1. Crestfallen life

The meaning of the word Crestfallen is feeling dejected, dispirited and discouraged. All these meanings turn true for a person undergoing dialysis, as they lead a life enduring experiences of abounding loss, hard pressed and deserted life.

a) Hard pressed life

All study participants echoed that their experience was hard pressed, which is transparent in the following words. The harsh effects of disease and treatment, financial drain, feelings of uncertainty about future, adhering to food and fluid restrictions and living with co-morbidities were the subcomponents included in hard pressed life. (*Names mentioned here are pseudonyms*)

Sreejith expressed *"This disease is a big trouble. As I told you, I used to pray everyday morning; let not even my enemies suffer this disease. I used to feel, that even cancer may not be such a deadly disease……... This disease is difficult…..I used to feel, let any other disease come, but not this disease…." He also added "Life is a tragedy for all those who are undergoing dialysis"*. He added *"weekly twice, I have to come and lie down like this for dialysis…to lie down like this……...Then when I come here, I have to lie down like a dead corpse, for nearly 4 hours. I am unable to turn or position myself during dialysis. I have to lie still these 4 hours"*.

Joseph also felt a nearly similar experience that he said *"I always pray, let not even my enemies suffer this disease, because it is like having bitten by a non- poisonous snake. You neither live nor die. There is an immediate cure for the rest of the diseases. But it is not so for this one. It just gets prolonged in spite of spending money or taking treatment. If we adhere and live as per to the physician's instructions, our life may still prolong"*.

The helpless situation of financial drain made all participants to feel that they are undergoing a hard pressed experience while on hemodialysis. They felt that life was squeezed into a hard pressed experience. Saranya verbalized that the financial crisis she experienced made her life difficult to meet ends. She says *"When life was getting settled in a good way, I started to suffer this disease. With that, life started to shatter**.** I ended up with a great financial crisis. Now itself, within 6 years, I have spent nearly 10 to 11 lakh rupees for this disease"*.

Few participants shared that, the feelings of uncertainty about the future and their kids made them feel terrible and their experience as hard pressed. Saranya was apprehensive that the

disease and treatment had an unexpected future, *"Because, this disease is unpredictable, as this is a killing disease. Though no symptoms are obvious outside, the effect of this disease is inside"*.

All the participants expressed a deep grief over the inability to take water and food as per to the heart's desire and felt it really disgusting. Thus the compelling force to adhere to fluid and diet restrictions was another aspect which made the participants to perceive their lived experience as hard pressed.

Paul said *"The most pressing desire for me is to drink water. During summer, I experience severe thirst. Hmm..I wish to drink water. I don't have much desire towards food. But to drink water…anyone will feel greedy to drink water. ……… but if I drink, I get admitted straight in ICU. I can drink water provided I have ten to fifteen thousand rupees in my hand"* [Hmm…smiling].

b) Abounding losses

Life while undergoing hemodialysis is an experience of abundant losses. Loss as said by participants varied from loss of physical strength to loss of job and prosperity. The loss experienced made them to narrate that, life is filled with change and can never be compared to the life lived before.

Most of the participants shared their experience of suffering a job loss. Saranya said, *"When I had a job, there was lot of benefits like financial status, relationship with people, social contacts and can mingle with others. But now all these are not there"*.

Few of them felt they were experiencing a loss of comfort and prosperity. Nazia verbalized "*Earlier I used to have servants in my home. They were there for nearly twelve years. When I fell sick, all that went off…I was living with all comforts as I was taken care of. … I also had a job....so I used to pay and keep people for work"*.

c) Deserted life

Patients undergoing hemodialysis experience a life of solitude especially when they feel abandoned by the relatives and friends. The deserted life experience was spelled by Saranya, *"Genuinely speaking, I feel like I don't have any relations…..Now meeting people happens only if there is utter necessity. More relationship (smiling) for me is only with hospital. I don't have relationship with anyone else, even with my family members, because I am unable to go and meet them."*

Suja said *"People used to come and visit me. They will visit. But it's not a helping relationship. When I was admitted in the hospital, there was none to visit me"*.

2. Support and comfort

Though experience of participants undergoing hemodialysis was narrated as a crestfallen life, still a ray of support was evident in their journey of dialysis. Subjects expressed the support from their spouse; few had a handful of support from relatives; and few entrusted their support to the Almighty God.

Suja was full of praise when she expressed the steadfast support given by her husband. In her words, *"My husband only takes care of me…even now. Only my husband will take care of me. The love of my husband is outstanding. Really I am alive today because of his love towards me…. He only brings and takes for dialysis. I live because of his support. If not, I would have died earlier"*.

Paul's support was from his in-laws and an aunt. He said, *"I have only my wife's parents…. As we don't have anybody else to take care of us, they are helping us... There is nobody else to help us. Only one aunty helps us"*.

3. Accompanying death

The curtain of death always seem to wave before the eyes of patients undergoing Hemodialysis, reminding them about the uncertain future that life holds for them. Most of the participants verbalized that the thoughts of death always accompanied them. Saranya expressed, *"because, this disease is unpredictable….as this is a killing disease. …..…Death may occur at any time…..I don't have any thoughts about my future"*. A similar experience was revealed in expressions of Joseph, *"I can't tell about myself sister…just a breathlessness may be enough to…I am learning by watching two three incidents….My life may get over with just breathlessness. Hmm..[tears in eyes]…..I myself am seeing a lot of patients who undergoing dialysis are becoming worse every day and then expire."*

4. Unfulfilled wishes

Patients undergoing Hemodialysis have numerous yearning wishes which due to their disease and treatment turn unfulfilled.

Joseph's wishes were to attend a social or family gathering like functions. He said, *"I used to feel, if I could have gone for a function, it would have been good to go and meet all of relatives and friends"*.

Nazia exclaimed her desire towards food and rest as, *"But sometimes when I see certain foods that I was eating previously, I used to have a desire to eat that….. Sometimes I used to think, if I was just able to take rest…to do nothing"*.

DISCUSSION

Four themes emerged from the lived experience of QOL among patients undergoing HD; crestfallen life, support and comfort, accompanying death and unfulfilled wishes.

A similar study finding of strict diet, fluid and strict schedule was reported in a study that was conducted to explore the lived experience of patients with ESRD in Oklahoma (Clarkson & Robinson, 2010). Some patients have described it as "strict renal diet and limitations on intake of fluid". In the compared study, a theme on limitations with the subtheme limited social contact was similar to the deserted life in the present study.

A similar concept of the theme accompanying death is evident in an Indian study that explored the lived experience among 10 persons undergoing haemodialysis in the dialysis unit of Kasturba Hospital (2014). The study concluded that the individual's life is centred on negatively oriented cognitions that can be modified with theoretically oriented interventions like cognitive behaviour therapy. This is consistent with the present study findings.

RECOMMENDATIONS

Psycho therapeutic interventional studies can be carried out to improve the QOL of HD patients, targeting the concepts of hard pressed, deserted life and to help them cope up with thoughts of abounding losses and accompanying death.

CONCLUSION

The findings shed light on the inner world of lived experiences regarding QOL by patients undergoing HD. More research studies are warranted to illuminate and intensify the knowledge in this area. The generated knowledge would be helpful to test new non-pharmacological interventions that may help patients undergoing HD to lead a life with better QOL and dignity.

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Post-Traumatic Stress Disorder: A Review from Clinical Perspective

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ABSTRACT

Post-traumatic stress disorder (PTSD) is being increasingly recognized and widely researched as a condition with high incidence but potentially preventable. It is increasingly associated with trauma of various types including hospital and intensive care admission (ICU) and is a now a recognized entity among the ICU survivors requiring a multidisciplinary approach including psychotherapy. The authors herein, give an overview of PTSD, including the recent diagnostic guidelines and an outline of the treatment.

Keywords: *Cognitive behavioral therapy, DSM-5, Eye movement desensitization and reprocessing, PTSD, Trauma.*

Post-traumatic stress disorder (PTSD) is a pathological mental state that may develop following exposure of the patient to a threatening or horrifying psychological event. This triggering event may be exposure to actual or threatened death, serious injury or sexual violation [1,2]. The prediction of a person developing PTSD remains a challenge as it may occur post a single traumatic event or after a prolonged trauma [3]. PTSD was first described in 1980 by the American Psychiatric Association in Diagnostic and Statistical Manual of Mental Disorders (DSM)-III [2].

Various types of traumas have been found to result in PTSD. The common events include:

- Military combat
- Violent personal assault
- Natural and man-made disasters
- Severe motor vehicle accidents
- Sexual violation like rape, incest, childhood sexual abuse
- Diagnosis of a life-threatening illness or hospitalization in an intensive care unit (ICU)

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Sexual violation- Sexually assaulted female survivors experience PTSD most frequently, most common offence related to PTSD being rape [4].

Military combat- Grieger et al. (2006) and Macgregor et al. (2013) in their studies concluded that PTSD occurring after combat injury to be directly proportional to the extent of injury [5,6].

Hospitalization in ICU- Girard et al. (2007) concluded in their study that PTSD occurred in as high as 14% of patients six months following critical illness requiring mechanical ventilation and were seen more in female patients and patients who received lorazepam. The same was observed by Bienvenu et al. (2015)[7,8].

Parker et al. (2015) in their well conducted systematic review and meta-analysis concluded that PTSD symptoms occurred in about 20% of critical illness survivors at 1-year follow-up [9]. A higher prevalence was seen in those who had pre-ICU comorbid psychopathology, received benzodiazepines, and had early memories of frightening ICU experiences.

Acute coronary syndrome (ACS)-A meta-analysis by Edmondson et al. (2012) which included 24 observational cohort studies with total 2383 patients yielded the prevalence of PTSD in about 12% of patients with ACS and also showed the increased risk for recurrent cardiac events and mortality in patients with PTSD [10].

Stroke/Transient ischemic attack (TIA)-Edmondson et al. (2013) in a systematic review and meta-analysis, which included nine studies, totaling 1138 patients, survivors of stroke or TIA, estimated the rate of PTSD following stroke or TIA was 23% [11].

Chronic illness- Spitzer et al. (2009) in their population-based study of 3171 adults in the community found a strong association between PTSD and cardiovascular and pulmonary diseases [12].

Mass conflict and displacement-Tay et al. (2015), in their cross-sectional community study (n = 230) of West Papuan refugees residing in Port Moresby, Papua New Guinea showed a direct relation of mass conflict and displacement with the development of PTSD [13].

It has been shown in various studies that the personal and social factors affect both the likelihood of developing PTSD after a traumatic event and also its clinical presentation (Stein et al. 2007; Kroll, 2003) [14,15]. The various risk factors for developing PTSD have been summarized in Box 1 (Vieweg et al. 2006; Bisson, 2007) [16,17].

Box 1: Factors associated with post-traumatic stress disorder
Pre-traumatic factors • Previous psychiatric disorder • Sex (more prevalent in female patients than in male patients) • Personality (external locus of control greater than internal locus of control) • Lower socioeconomic status • Lack of education • Race (minority status) • Previous trauma • Family history of psychiatric disorders
Peri-traumatic factors • Severity of trauma • Perceived threat to life • Peri-traumatic emotions • Peri-traumatic dissociation
Post-traumatic factors • Perceived lack of social support • Subsequent life stress

The frequency with which PTSD occurs after a traumatic event is influenced by characteristics of the individual and the inciting event (Yehuda, 2002) [18]. Overall, women are four times more likely to develop PTSD than men, after exposure to traumatic events [16].

Diagnosis of PTSD

The nature of traumatic events for the diagnosis of PTSD by the DSM-5 [1] and the proposed criteria by ICD-11(international classification of diseases, 11th revision) by Maercker et al. (2013) [19] are listed in table 1 and the symptoms for the diagnosis of PTSD as listed by DSM-5 and ICD-11 are elaborated in table 2.

Table 1:

Traumatic event(s) required for diagnosis of PTSD
DSM-5 criteria Exposure to actual or threatened death, serious injury, or sexual violation, in one or more of the following ways: Directly experiencing the traumatic event(s) Witnessing traumatic event(s) in others Learning that the traumatic event(s) occurred to a close family member or close friend; cases of actual or threatened death must have been violent or unintentional Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (for example, first responders collecting human remains; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related
Proposed ICD-11 criterion Exposure to an extremely threatening or horrific event or series of events

Table 2:

DSM-5 criteria	Proposed ICD-11 criteria
Intrusion symptoms Recurrent, involuntary and intrusive distressing memories Recurrent distressing dreams (content and/or affect related) Dissociative reaction (acting or feeling as if the event is recurring) Intense or prolonged psychological distress to cues Noticeable physiological reactions to cues	**Intrusion symptoms** Vivid intrusive memories, flashbacks, or nightmares, typically accompanied by strong and overwhelming emotions such as fear or horror, and strong physical sensations
Avoidance Avoidance or efforts to avoid distressing thoughts or feelings about or closely associated with the trauma Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations)	**Avoidance** Avoidance of thoughts and memories of the event or events Avoidance of activities, situations, or people reminiscent of the event or events
Negative alterations in cognition and mood Inability to remember an important aspect (typically due to dissociative amnesia) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (for example, "I am bad, "No one can be trusted," "The world is completely dangerous") Persistent, distorted cognitions about the cause or consequences that lead to self-blame or the blame of others Persistent negative emotional state (for example, fear, horror, anger, guilt, shame) Noticeably diminished interest or participation in important activities Feelings of detachment or estrangement from others Persistent inability to experience positive emotions (for example, happiness, satisfaction, love)	**Negative alterations in cognition and mood** Not applicable

Alterations in arousal and reactivity Irritable behaviour and angry outbursts (with little or no provocation) Reckless or self-destructive behaviour Hyper vigilance Exaggerated startle response Problems with concentration Sleep disturbance	**Alterations in arousal and reactivity** Persistent perceptions of heightened current threat—for example, as indicated by hyper vigilance or an enhanced startle reaction to stimuli such as unexpected noises
Additional criteria for complex PTSD Not applicable	**Additional criteria for complex PTSD** Severe and pervasive problems in affect regulation Persistent beliefs about oneself as diminished, defeated, or worthless, accompanied by deep and pervasive feelings of shame, guilt, or failure related to the stressor Persistent difficulties in sustaining relationships and in feeling close to others

A diagnosis of PTSD is made in someone who develops an inability to function normally for more than one month according to DSM-5 criteria.

A multi-center cohort study conducted by Roberts et al. 2007,concluded that the majority of the patients have factual memories of their intensive care unit (ICU) stay and are thus prone to develop PTSD due to stress related to critical illness and highlighted the need for continued patient information, re-assurance and comfort to the patient [20]. The same results were also observed in a prospective study by Badia-Castellóet al. (2006) [21].

Management of PTSD

Post-traumatic stress disorder (PTSD) is often a severe, chronic and disabling disorder which is best treated/managed by a combination of pharmacological and non-pharmacological therapies. The psychotherapy is the primary treatment. Medications are usually required to control the physiological symptoms, which helps the patient to tolerate and work through the psychotherapy.

Types of psychotherapy

- **Trauma-focused cognitive-behavioral therapy (CBT):** It is considered the first line therapy and involves careful and gradual exposure of the patient to the thoughts, feelings, and situations that remind him of the trauma. The therapy also helps to identify the upsetting thoughts about the traumatic event (particularly the distorted and irrational thoughts) and replaces them with a more balanced picture.

- **EMDR (Eye Movement Desensitization and Reprocessing):** This includes the elements of CBT with eye movements or other rhythmic, left-right stimulation like hand taps or sounds. This works by "unfreezing" the brain's information processing system, which has been interrupted during the time of extreme stress.
- **Exposure therapy.** This type of behavioral therapy helps in safely facing the perceived frightening situation so as to make the patient learn to cope with it effectively. This therapy may also use "virtual reality" program that allows the patient to re-enter the situation in which the trauma was experienced.

Meta-analysis by Hogberget et al. (2008) [22], Ponniah et al. (2009) [23] and Bronson et al. (2007) [24] involving studies in adults with PTSD showed that trauma-focused CBT and EMDR should be the first-line non-pharmacological therapies for PTSD. A randomized controlled trial (RCT) by Nijdam (2012) [25], which compared the trauma-focused CBT modality of brief eclectic psychotherapy and EMDR, found that both of them are effective psychotherapeutic interventions, but EMDR is more time-efficient method for treating PTSD.

Studies by Germain et al. (2007) [26] and Raskind et al. (2007) [27] suggested that even a single CBT for sleep abnormalities can significantly improve daytime PTSD symptoms, as can pharmacological treatments for sleep abnormalities. In a RCT by Litz et al. (2007) [28] on the service members with PTSD caused by the traumatic events of war, self-managed CBT led to a greater reduction in PTSD symptoms in comparison to the internet-based supportive counseling.

Medications

Several types of medications can help improve symptoms of PTSD [29]:

- **Antidepressants.** These medicines help to reduce the symptoms of depression and anxiety, thus improving the concentration and decrease sleep related issues. The selective serotonin reuptake inhibitor (SSRI) medications sertraline and paroxetine are approved by the Food and Drug Administration (FDA) for PTSD treatment.
- **Anti-anxiety medications.** These medicines help in decreasing the anxiety and stress symptoms for a brief period of time, as they cannot be prescribed for long term due their potential for abuse.
- **Prazosin.** This drug has been seen to be helpful in symptoms of insomnia or recurrent nightmares, although it is not specifically FDA-approved for PTSD treatment [29,30].

A prospective, multicenter cohort study by Jackson et al. (2014) [31], showed that upto seven percent (%) of ICU survivors have symptoms of PTSD. Bienvenuet al. (2013) [32], in their study showed the prevalence of PTSD as high as 27% in patients surviving acute lung injury.

CONCLUSIONS:

Considering the high incidence of PTSD in ICU survivors and trauma survivors and the effect on their life, it is suggested that the patients who recover from critical illness or have been through a

traumatic event should undergo evaluation for PTSD in their initial visit or follow-up visit with the primary physician and may require CBT and psychological support.

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A Study of Emotional Intelligence of Scheduled Caste and Non-Scheduled Caste Students

Arun Prakash Krishna Vimal[1]*, Dr. Smita Jaiswal[2]

ABSTRACT

The study was under taken to study the Emotional Intelligence of scheduled caste and non-scheduled caste students. Total sample consisted of randomly selected 400 students from various colleges (arts, science and commerce) of Kanpur city of Uttar Pradesh. Of these four hundred students 200 were scheduled caste and 200 were non-scheduled caste. Data was statically analysied by 'ANOVA'. The result revealed that non-scheduled caste students have better emotional intelligence than scheduled caste students.

Keywords: *Emotional Intelligence, Scheduled Caste, Non-Scheduled Caste, Student.*

The cultural diversity of Indian society stands a distinctive characteristic of different castes and communities. Each caste practices certain dispositions which mold and shape the product which is affected very much by the reactions from the society and its people. The whole society may be divided on the basis of caste religions wealth and region.

This cultural diversity and social discrimination how much affects the emotional intelligence? Present study was designed to find out the answer. A few numbers of studies have revealed controversial results.

Patel A. C. (2012) - Found that the level of confidence is similar for the male scheduled caste students having high and low emotional intelligence. The level of confidence is much higher for the female scheduled caste students of high school having high emotional intelligence than for the female students of the same caste and the same grade but having low emotional intelligence. The emotional intelligence is similar for the female schedule caste students having high and low emotional intelligence.

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Brar P. K. (2014) - Found that general caste students are to be higher on empathy, self-motivation, managing relations, self-development and emotional intelligence as compared to students of scheduled caste category.

Lekhi (2005) in her study on a sample of 939 male and female adolescents found that adolescents of general category were having higher level of emotional maturity as compared to the adolescents of scheduled caste category.

Jaidka M. L. (2012) found of no significant difference in Emotional Intelligence of the Scheduled caste and Non Scheduled caste pupil teachers on their teaching competency.

Keeping all these views in mind present study was designed.

Purpose

Purpose of the study is to compare the level of Emotional Intelligence of Scheduled Caste and Non-Scheduled Caste students.

Hypothesis

It was hypothesized that there is no significant difference in Emotional Intelligence of Scheduled Caste and Non-Scheduled Caste students.

Sample

The sample consisted of randomly selected 400 students from various colleges (arts, science and commerce) of Kanpur city of Uttar Pradesh. Of these four hundred students 200 were scheduled caste and 200 were non-scheduled caste. The sample was divided into four groups on the basis of gender. All the subjects were from the same age range (17 to 25 years), socio economic status and educational level.

Tools

Assessing Emotional Scale by **N. S. Schutte et al.** was used to measure the Emotional Intelligence.

Statistical analysis

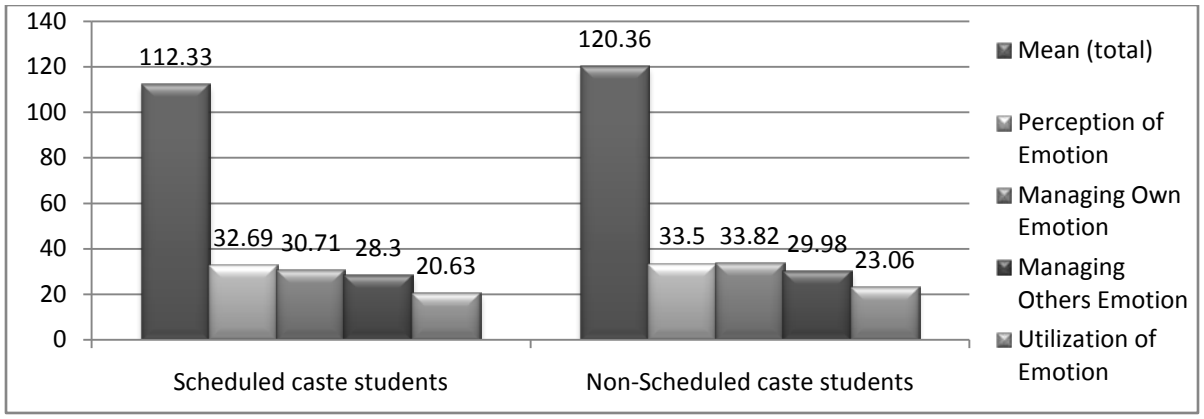
Result is analysis by single factor Analysis of variance ‘ANOVA’.

RESULT AND DISCUSSION

Comparison of Emotional Intelligence and its four factors of Scheduled Caste and Non-Scheduled Caste Students

Table No-1 showing mean and S. D. of Emotional Intelligence of scheduled caste and non-scheduled caste student.

		Scheduled Caste Students		Non-Scheduled Caste Students	
N		**200**		**200**	
		Mean	**S. D.**	**Mean**	**S. D.**
Emotional Intelligence	**Perception of Emotion**	32.69	5.47	33.5	6.12
	Managing Own Emotion	30.71	5.98	33.82	6.84
	Managing Others Emotion	28.30	5.13	29.98	5.24
	Utilization of Emotion	20.63	4.08	23.06	4.98
Total Mean		112.33		120.36	
Standard Deviation		15.93		17.91	



Showing the total Mean score of Emotional intelligence and its four factors on Scheduled Caste and Non-Scheduled Caste students.

Diagram shows that non-scheduled caste students have better emotional intelligence as whole (mean=120.36) than scheduled caste (mean=112.33). Non-scheduled caste students have better perception of emotion (mean=33.5) than scheduled caste (mean=32.69). Managing own emotion of non-scheduled caste students have better (mean=33.82) than scheduled caste (mean=30.71). Managing others emotions of non-scheduled caste students have (mean=29.98) and scheduled caste (mean=28.30). Utilization of emotion of non-scheduled caste students have better (mean=23.06) than scheduled caste (mean=20.63).

This finding shows that non-scheduled caste students have better emotional intelligence than scheduled caste students. They are good at perception of emotion, Managing own emotion, Managing others emotion and Utilization of emotion.

Table No. - (2) ANOVA Summary

In this section an attempt has been made to find out the effect of caste on Emotional Intelligence. Single factor design was used and analysis of variance was calculated.

Sources of variation	Sum of Square	d. f.	Mean square	F-Ratio
Between groups	6456.12	1	6456.12	22.46>.01
Within groups	114387.96	398	287.41	
	120844.08	399		

Significant level at .05=>3.86 & .01=>6.70

Table No. (2) Reveals that caste significantly affect Emotional Intelligence (F-Ratio=22.46, Significant at .01level). Thus the hypothesis stating that 'there is no significant difference in emotional intelligence of scheduled caste and non-scheduled caste students' is rejected.

CONCLUSION

There is a significant difference between emotional intelligence of scheduled caste and non-scheduled caste students. This finding revealed that Emotional intelligence of non-scheduled caste students was better than scheduled caste students and significant difference between non-scheduled caste and scheduled caste students was found.

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A Comprehensive View of Self-Concept and Its Effect With Respect To Self-Mutilation among the Institutionalized and Non-Institutionalized Adolescents

Dr. Joshy V. Anthony[1]*, Dr. S. John Michael Raj[2]

ABSTRACT

The objective of this study is to synthesize information from existing literatures on measures of the self-concept among institutionalized and non-institutionalized adolescents with respect to self-mutilation. As for an adolescent is concerned, it is important to develop a positive self-concept and high self-esteem in order to enhance a healthier personality. So the main objectives and focus of this study is to monitor the self-worth of adolescent students and help improve one's self-concept and thus to develop a sense of healthy personality as an autonomous individual. 985 adolescent students, Kerala, India formed the sample for the study. The Self-Concept Questionnaire ((Kagen, Moore, & Bredekamp, 1995)) and Self-Harm Inventory (Randy A. Sansone, and Lori A. Sansone1998), were used. 2x2x2 factorial ANOVA, Regression Analysis and Correlation technique were used to analyse the data. The findings showed that the levels of self-concept seem to influence the levels of self-mutilating behaviour among the adolescent students.

Keywords: *Family-Functioning, Institutionalization, Peer-Influence, Self-Concept, Self-Mutilation.*

Self-concept is the 'corner stone of both social and emotional development' in all people in general and adolescents in particular (Kagen, Moore, & Bredekamp, 1995). Researchers reveal that the enhancement of this construct in one's life, as a vital factor, especially, in achieving and fostering academics as well as social and emotional experiences is of greater importance (Byrne et al., 1992; Harter, 1983; Marsh et al., 1991; Rambo, 1982; Stipek, Recchia, & McClintic, 1992). Clinical psychologists expose that a healthy and positive self-concept is a better means to deal with life stresses which in turn helps to achieve more in lives (Coopersmith, 1967).

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Cook, (1987) on the other hand, described self-concept, in broader sense, as the sum of all experiences across the life span that affect not only our opinions, behaviours, and social interactions but also, the evaluations as well. As for an adolescent is concerned, it is important to develop a positive self-concept and high self-esteem in order to enhance a healthier personality which of course helps one to put up a happy and satisfying adulthood. So the main objectives and focus of this study is to monitor the self-worth of adolescent students and help improve one's self-concept for the reason that, the key task in confronting the adolescent is to develop a sense of 'self' as an autonomous individual. Nevertheless, the development of self-concept occurs, as a result of one's experiences with the environment and one's evaluations of these experiences. Besides this, the opinions from significant others, family members, family functioning, peers, casual attributions, and concrete feedback play a crucial role in the process of self-concept development (Shavelson, Hubner, & Stanton, 1976).

There are categories of adolescents one come across in the society, especially, institutionalized, non-institutionalized and orphan, juvenile and street adolescents, Here the focus of the study is based on the first two categories, i.e., institutionalized and non-institutionalized adolescents. Even though, adolescents of institutionalized and non- institutionalized may not be the similar, identifying the levels of self- concept of these two categories is essential in order to understand clearly the psycho-sociological levels of adolescents.

Institutional adolescents are those children who have been receiving long term service or who resides in an institutional setting or care homes can be called institutionalized adolescents (Ainsworth& Frank& Leon, 1981), will not be enjoying the positive and creative atmosphere, which in turn, can create a low level of self –concept and greater psycho-social problems later on. The lack of confidence, the fearful nature, behavioural problems, such as, self-mutilation (self-injury) immaturation, feeling of over attachment, dependence, suspecting everybody, inadequate communication, lack of sleep, etc are some of the major features one find in adolescent students, which can bring down the levels of self-concept.

Non-Institutionalized adolescents are those students who stay with parents, family and near and dear ones. Positive and frequent family involvement has a significant role in fostering confident self-concept in adolescents. So the adolescents with family and parents may not be having many difficulties, because, the creative family and energetic parents give the ways to eliminate the problem of negative views about one's self-concept. The more communication between parents and the children, more achievement will be the result in them. If the family fails to give adequate assurance and provide flexible environments that respond to the adolescents' emerging maturity and independence the end will be terrible. Self-concept is not an empty process, as it has greater influence in the family context, even though, self-concept is also be influenced by outside the family, such as peers, and school. Family atmosphere has significant role in moulding up and predicting the adolescent externalizing behaviour. As it is stated, positive family communication

is a key in helping adolescents to maintain a constructive self-concept and high self-esteem (Ochoa, Lopez, and Emler, 2007).

Another important element in constructing one's self-concept in adolescent period is school. To enhance self-concept, teachers, educators will then be more apt individuals (Moller et at, 2009). Teachers are big influential factors to clearly delineate between self-concept and self-esteem. When students have negative self-concept and a low self-esteem, the emotional welfare of the students suffers, while, when adolescents have a strong self-concept, they are able to conquer a better positions in society and this in turn can facilitate a strong personality (Trautwein et aI. 2006). As for many students with institutionalization, it can be frustrating to cope with one's disability within the general behavioural settings. Research has shown that students with institutionalization have a more negative self-concept compared to students who are non-institutionalized. For the reason that, self-concept pertains to a student's overall sense of worth.

Peer influence is a further significant constituent in up bringing the sense of self-concept in adolescents. The good or bad, creative or non-creative peer groups have major role to obtain this special construct. Compared to children under age 10, adolescents spend a good amount of time outside of the home. They spend much more time with peers who are relatively equal in terms of interpersonal power and authority. In this connection, Marsh (2005) found that a student's self-concept is partially dependent on his or her surroundings. He describes this as the 'big-fish-little-pond effect' (BFLPE). If the average ability of classmates is high, equally able students most likely will have a more negative self-concept.

However, if the average ability in a given student's class is low, then he or she is more likely to have a positive self-concept.

This limitation on self-concept can have a direct influence on the development of an adolescents' overall performance in establishing a healthier personal identity. Furthermore, higher peer stress and less companionship have been associated with a lower social self-concept in adolescents (Wenz-Gross, Siperstein, Untoh, & Widaman, 1997). The research literature suggests that peer group programs can produce orderly, productive, and positive academic and rehabilitative environments. Above all, one can conclude that, self-concept is the perception that individuals have of one's own worth, which comprises the feelings of oneself, as well as, view of one's social acceptance in the society (Belmore & Cillessen, 2006).

Self-concept has greater impact in setting up one's goal and therefore healthy, realistic views of oneself (Clinic, 2009). The adolescents with low self-concept keep little value on oneself and the accomplishments that are to be done. Furthermore, worthless feeling, the feeling of good for nothing, etc, can harm one's self-confidence. At times one may have the greater reflections of shamefulness of one's state of life, which in turn can become a cause to engage in negative self-

talk. These perennial issues may create nervousness in one's life and can create a stress and anxiety–depression that puts down in developing lowering self-concept and self-confidence.

Self-Concept and Self-Mutilation

There are many problems that adolescents come across all over the world and one of the greatest behavioural problems of adolescents is the self-mutilation (SM). Self-mutilation, which is also known as self-injury, has been referred to as the "fastest-growing adolescent behavioural problem" (Purington & Whitlock, 2004). It has been reported that the increase in the rate of self-mutilation has its derivation since 1960s, even then, the report of SM have been well known throughout the history. Moreover, the concept of self-mutilation(SM) has become an increasing problem among adolescents since the 1990s. According to Peterson, & Seligman, (2004), self-mutilation which is also known as non-suicidal self injury (NSSI) is usually seen in adolescent and young adult populations. The research done in community study in recent years have found that one-third to one-half of adolescents in the total population have engaged in some type of non-suicidal self injury.

Taylor, (2003) described it as any behaviour that is not good for the human body. Galley, DeGeer, Deur, Alfonso, and Fenton, (2003, 2005 and 2007), illustrates self-injury as a 'silent school crisis' due to insufficient knowledge, confusion, lack of effective interventions in dealing directly with the tissue. Favazza (1998) defines self-mutilation as the deliberate destruction to the body tissue without the conscious suicidal intention. And again victimization by peers, parental emotional neglect, childhood sexual abuse, insecure attachment, anxiety, depression, low self-esteem, body dissatisfaction, poor school achievement, drug consumption, dissociative symptoms, and general psychopathology are well said to be associated with the SM (Brodsky, Bjärehed & Lundh, 1995 and 2008).

Youngleson, (1973) investigated study comparing 24 institutionalized children and a matched control group, and the findings show that institutionalized children were less well put up in the self-concept and that they manifest less self-esteem so much so more prone to self-harming behaviour and are less adjusted compared with a control group. Tizard and Hodges, (1978) extended the study between 65 of the institutionalized and 26 formerly institutionalized children showed that significant differences were found between institutionalized or previously institutionalized children and their non-institutionalized counterparts on total problem behaviours and anti-social scores. Deviations included restless behaviour, highly mutilating one, poor peer relations, disciplinary problems and disruptive attention-seeking behaviour among children who had been institutionalized.

Suneetha and Vijayalaxmy (2007), done research with 75 adolescents of employed mothers and 75 adolescents of homemakers of North Karnataka, explains that, self-concept, emotional maturity and achievement motivation of the adolescent children of employed mothers and

homemakers, have significantly higher self-concept. Muni (1995), observed that adolescents of employed mothers had a positive physical, intellectual and educational self-concept and were better adjusted than the children of housewives. Milan, (2008) reveal that there exist a significant relationship between self-concept levels and sex of the students of 11th class students. Self-concept of the boys of std 11th was found very less while the levels of self-concept of girls were high.

Ubangha and Oputa, (2008) carried out a study in differences in self-concept, academic orientation and vocational interests of normal and institutionalised adolescents in logos metropolis. Institutional Children differed in academic orientation and vocational interests, in which the vocational orientation was not well oriented with the the institutionalized adolescents. These findings were discussed in the light of their implications for bridging the gap between institutionalized and normal children. Kimani Chege Gabriel, Cheboswony, Kodero and Misigo Benard, (2009) reveals that, there was a difference in self-concept and academic performance between institutionalized adolescents and those living with extended families, guardian homes and in parental homes.

Pamela, Sarah and Laurie, (2000) investigated on self-Injury and self capacities among adolescents. Here the researchers were trying to find out the individuals who are in Crisis. The participants were 233 from clinics and normal answered questions with regard to self-injury, abuse history, and three self capacities which constitute the ability to tolerate strong affect, the ability to maintain a sense of self-worth, and the ability to maintain a sense of connection to others. In the study 60% reveal childhood abuse, nearly half reported self-injury. These two groups showed greater impairments in self capacities and self-administration. The feeling of self-worthiness is not seen in the subjects who took part in the investigation. Individuals with a history of childhood abuse showed greater impairment than did individuals who did not report childhood abuse. Greatest impairment was associated with both self-injury and abuse.

Rory, Susan and Jeremy, (2009) point out that 13.8% of the adolescents had the habit of self-harm at least for once in life. Girls were more addicted to these behavioural problems and about 3.4 times more likely to report self-harm than boys. The researchers found that the associations with these are smoking, bullying, worries about sexual orientation, self-harm by family and anxiety were associated with self-harm in both genders. In addition, drug use, physical abuse, serious boy or girlfriend problems, self-harm by friends and low levels of optimism and low self-concept were also associated with self-harm in girls. Therefore, the investigators suggest that emotional awareness programmes in schools and family which highlight the importance of promoting positive mental health among adolescents are mandatory.

The existing literatures prove that self-concept play a vital role in forming the person's healthy personality. This study is thus centred on a descriptive areas specifically investigating: (1) how

high self-concept helps and enhances one to minimises the self-mutilating behaviour, (2) how gender differs from each other especially in augmentation of self-concept, and (3) how this perceived individual make it better in social consequences.

FOCUS OF THE STUDY

Objectives:

- To find out the relationships between the dimensions of self-concept, and self-mutilation among the institutionalized and non-institutionalized adolescents.
- To assess the effect of self-concept on self-mutilation and its sub-dimensions among the institutionalized and non-institutionalized adolescents
- To determine whether self-concept predicts the changes in self-mutilation among the institutionalized and non-institutionalized adolescents.

Hypotheses:

1. There will be significant relationships between dimensions of self-concept and self-mutilation among the institutionalized and non-institutionalized adolescents.
2. There will be significant difference between high and low self-concept groups and gender and types with respect to Self-Mutilation(SM) of the institutionalized and non-institutionalized adolescents
3. It is possible to predict the changes of self-mutilation by the independent variable self-concept

METHODS

Participants/samples

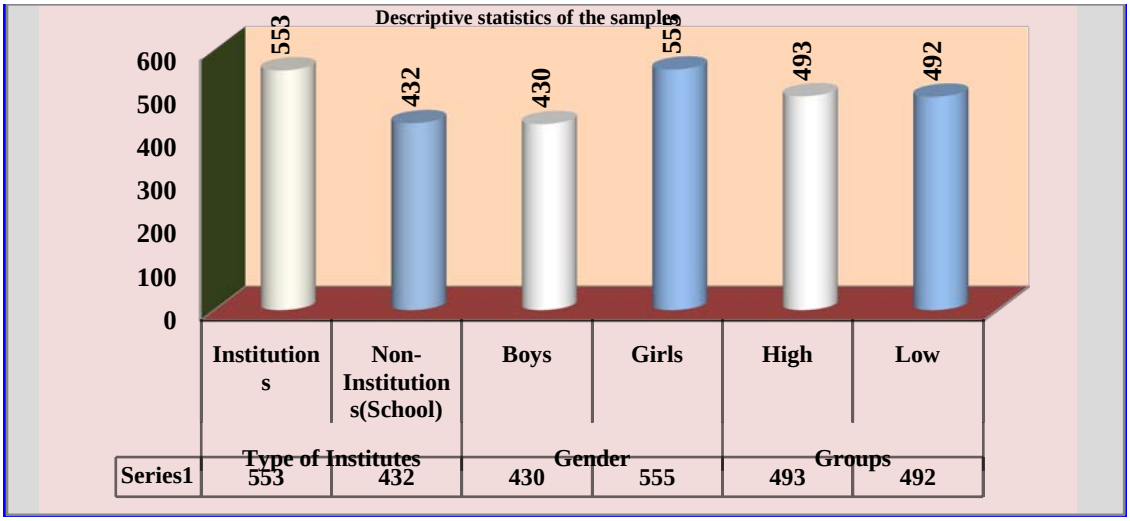
Descriptive Statistics of the Sample

The Table 1and the figure 1 shows the descriptive statistics of the samples collected for the research. The total data collected from the institutionalized adolescents are 553 and non-institutionalized adolescents are 432 and total sample represent 985. For the better notion of the samples, the researcher arranged the samples as gender-boys and girls, and self-concept high and low. The table reveals that the total number of gender, namely boys is 430, and girls 555 respectively. The description of groups, namely high group are 493, and low group 492 respectively.

Table: 1 shows the descriptive statistics of the samples taken for the study.

Category			Total
Type of Institutes	Institutions	553	985
	Non-Institutions(School)	432	
Gender	Boys	430	985
	Girls	555	
Groups	High	493	985
	Low	492	
Total			**985**

Figure: 1: shows the descriptive statistics of the samples selected for the main study



Instruments and Procedure

I) The level of self-concept was measured using Self-Concept Questionnaire (SCQ) developed by Raj Kumar Saraswat (1981). This is a 48 item self-report questionnaire designed to measure factors that reflect self-concept of the respondents.

II) The self-mutilating behaviour of adolescent students is measured by using Self-Harm Inventory developed by Randy A. Sansone, and Lori A. Sansone (1998). It is a one-page, 22-items, YES/NO, self-report questionnaire that explores respondents' histories of self-harm. A short socio-demographic section investigates participant's gender, types, were also calculated.

Statistical tools

Statistical Analysis and Techniques

Following statistical techniques are used for the analysis of present investigation and they are:

- Probability plot to check the normality of the sample.
- Correlation among the variables to find out the relations ships between types, gender, groups on the self-concept, and self-mutilation.
- 2x2x2 factorial ANOVA to check the effect and interaction effect among the self-concept high and low group, types of institutions-institutional and non-institutional and gender-boys and girls.
- Regression Analysis to account for the expansion of prediction of the variables i.e., self-mutilation by the independent variable self-concept as well as to account for the changes in the dependent variable upon the changes in the independent variable.

RESULTS AND DISCUSSION

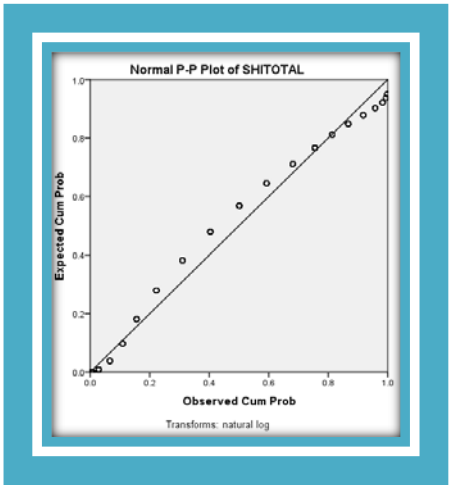
The Probability –Bar chart of the Data

According to Thorndike, (1913) perfect normality may not occur in the social sciences. Therefore, variations of normality to a small extent are accounted in the present study as well. Moreover, the researcher whispered that the statistical power will be ample to meet the criteria of normality limit and large sample size being met. Since the sample sizes covers nearly 1200 the researcher selected the Kolmogorov-Smirnov *Z* test of normality was used to screen all the variables in the data. The results pertaining to the frequency distribution of the variables self-concept, self-mutilation are given in table 2.

Table 2: shows the Kolmogorov-Smirnov Z test of normality for self-mutilation scale.

Variable	Normal Parameters		Kolmogorov-Smirnov Z	Sig.
	Mean	SD		
Self-mutilation	9.247	3.835	1.075	NS

Figure 2: Shows the Normal Probability Plot of Self-Mutilation total score (N=985)



From the table and figure 2, it can be inferred that the observed data for self-concept, and self-mutilation are nearing to normal. The ascending nature of the slope in the figures point out that the data is in close approximation. Besides, the big number of samples collected for the study gives the researcher a huge expectation with high statistical power. This makes the investigator to proceed with a parametric test for analysing the variables of the descriptive survey to understand the effect of self-concept on self-mutilation among institutionalized and non-institutionalized adolescents.

1. Correlations of Variables

The relationships among the variables studied in the sample were analysed using the statistical technique of Correlation Matrixes. The hypothesis corresponding to the relationship between the variables of self-concept, and self-mutilation is presented below in order to facilitate comprehending the results presented in this section. The hypotheses formed for showing relationships between all these are displayed once again here below.

1. There will be significant relationships between dimensions of self-concept and self-mutilation among the institutionalized and non-institutionalized adolescents.

Table 3: shows the Correlation matrixes among the variables, of the participants' self-concept and self-mutilation

Variables		***Self-Concept***						***Self-Mutilation***
		PHY	**SOC**	**TEM**	**EDU**	**MOR**	**INT**	**Self-Mutilation**
Self-Concept	PHY	1.000	0.633**	0.662**	0.615**	0.570**	0.580**	-0.076*
	SOC		1.000	0.604**	0.587**	0.590**	0.587**	-0.020
	TEM			1.000	0.633**	0.578**	0.608**	-0.002
	EDU				1.000	0.603**	0.578**	-0.063*
	MOR					1.000	0.561**	-0.058
	INT						1.000	-0.043
Self-mutilation	SM							1.000

** Correlation is significant at 0.01 levels.

* Correlation is significant at 0.05 levels.

PHY-Physical, SOC-Social, TEM-Temperamental, EDU-educational, MOR-Moral, INT-Intellectual and SM-Self-Mutilation

The table 3 displays the correlation on the results obtained among the variables. The correlation has done in all psychological variables' sub-dimensions. Such as, correlation between self-concept and its six dimensions, between these three and self-mutilation, respectively. Among these, 2 cases show there exist negative correlation at the $P<.05$ level. Rests of the correlations are not significant. Among the self-mutilation there was no significant correlation found. Self-

mutilation showed negative correlation with other dimensions of self-concept such as, social, temperamental, moral, and intellectual dimensions.

2. Comparison of the variables

The data collected were analyzed for comparison using the technique of 2x2x2 factorial ANOVA. Here the main comparisons were made between self-concept high and low group, types of institutions and gender-boys and girls on psychological variables, and self-mutilation.

H.2.1 There will be significant difference between the high and low levels of self-concept of the adolescents on self-mutilation.

H.2.2 There will be significant difference between institution and non-institution adolescents on self-mutilation.

H. 2.3 There will be significant difference between adolescent boys and adolescent girls on self-mutilation.

H.2.4 There will be significant interaction between the levels of self-concept with respect to institutional and non-institutional adolescents, boys and girls on self-mutilation.

Table 4: shows the summary of 2x2x2 way ANOVA on self-concept with respect to self – mutilation

Source	*SS*	*df*	*MS*	*F*	*Sig.*
Between high and low self-concept groups	23.158	1	23.158	1.382	Ns
Between types-institutional and non-institutional	28.969	1	28.969	1.729	Ns
Between gender-boys and girls	14.499	1	14.499	0.865	Ns
Interaction between groups and types and gender	22.645	1	22.645	1.351	Ns
Total	16515.194	984			

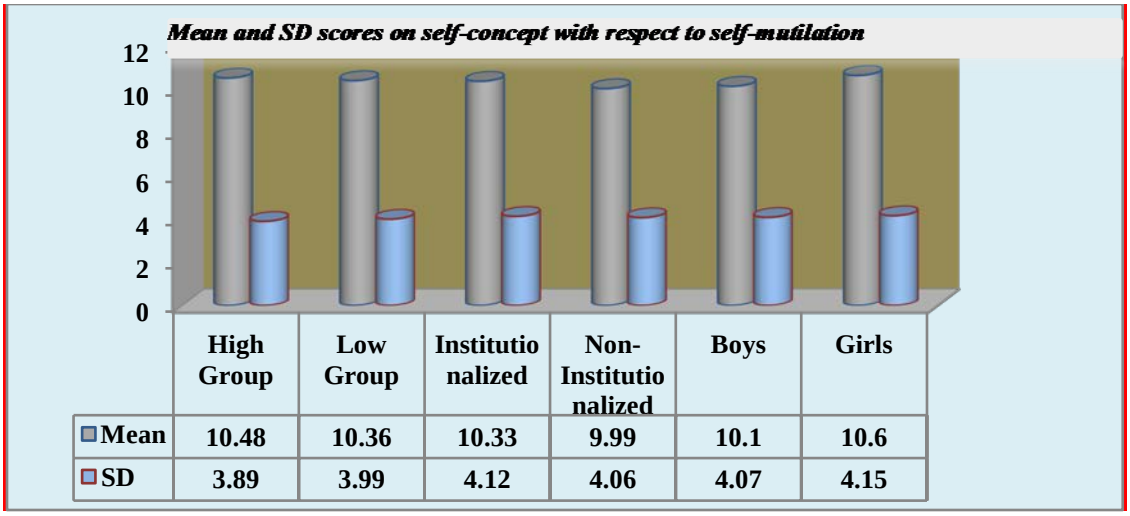
Ns= Not Significant

The Table 4 shows the result summary of 2x2x2 way ANOVA on self-concept with respect to self-mutilation.

The calculated *f*- ratio value relating to high and low self-concept groups on their self-mutilation is 1.382. It has not attained statistical significance. Hence, hypothesis 2.1.is rejected. The *f*-ratio value relating to types on self-mutilation is 1.729. It has not attained statistical significance. Hence, hypothesis 2.2 is rejected. Moreover, the calculated *f*-ratio value for gender comparison between male and female is 0.865. It has not attained statistical significance. Hence, hypothesis 2.3 is rejected. Besides, three way interaction effects between male and female and between institutionalized and non-institutionalized and between self-concept high groups and low groups were studied. Since the *f*-ratio relating to interaction effect is 1.351, it shows that it has also not

attained significant interaction effect between male and female and between institutionalized and non-Institutionalized and between self-concept high and low groups. Hence, hypothesis 2.4 is rejected.

Figure 3: shows the Mean and SD scores on self-concept with respect to self-mutilation(SM)



	High Group	Low Group	Institutionalized	Non-Institutionalized	Boys	Girls
Mean	10.48	10.36	10.33	9.99	10.1	10.6
SD	3.89	3.99	4.12	4.06	4.07	4.15

As may be seen from the figure 3, the mean values of the high and low self-concept groups are 10.48, 10.36 and the mean values of institutionalized and non-institutionalized are 10.33 and 9.99. Moreover, the mean values of boys and girls are 10.10 and 10.60 respectively. Hence, it is evident that all the students regardless of groups, types and gender are having the more or less equal mean values.

3. Multiple Regression Analyses

Regression analysis enables the researcher for predictive model in order to use it to predict the value of the dependent variable from one or more independent variables. And the multiple regression analyses help a researcher to predict an outcome from several predictors. The results obtained using these statistical techniques are reported in the following sections.

3.1 It is possible to predict the changes of self-mutilation by the independent variable self-concept

The effect of self-concept on self-mutilation was studied using Regression analysis. The Regression results are best explained given in following section. From the table it is clear that self-concept have positive effect on self-mutilation. That is, increase in each of these dimensions will result in proportionate increase in overall self-mutilation scores.

Table 5: shows the Regression Coefficients of the participants associated with self-concept and its dimensions predicts to self-mutilation.

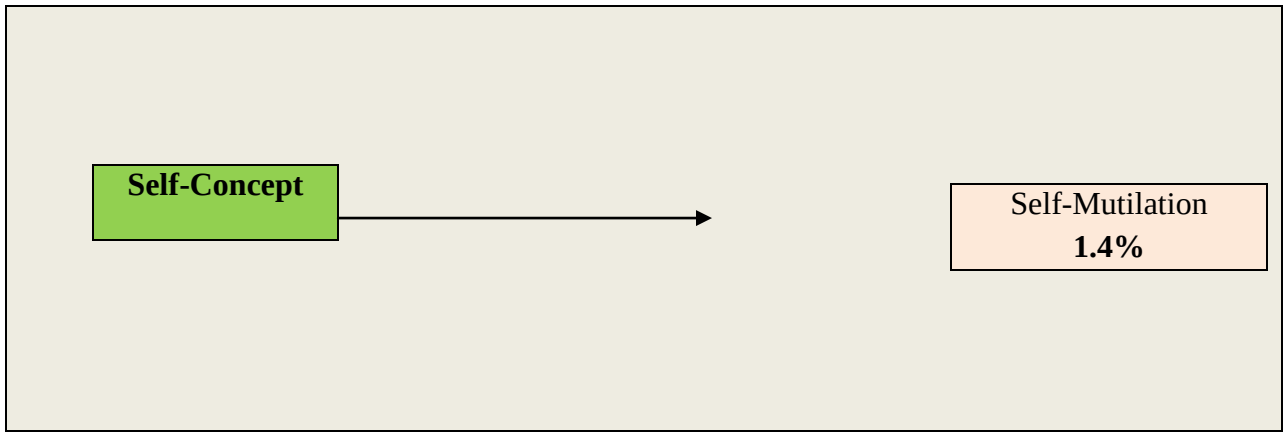
Predictors	*DV*	*(B)*	*Std. Err*	*R*	*R Square*	*F*
Self-Concept	*SM*	*-0.005*	0.007	*0.120*	*0.014*	*0.394**

DV-Dependent Variables, SM-Self-Mutilation.

In the Table 5, it is inferred that the regression of independent variable self-concept contribute significantly for the dependent variable self-mutilation. The 'B' values are unstandardized coefficients. The unstandardized coefficients are -0.005 for self-mutilation with the standard errors of 0.007. . This implies that for every unit of change in self-mutilation there is -0.005 units of change in self-concept concordantly as per the influence of the variable self-mutilation. This gives us the idea that the independent variable self-concept has a greater role in predicting the dependent variable self-mutilation.

In the table 5, the multiple '*R*' is 0.120 and '*R*' square is 0.014 for self-mutilation. The '*R*' value indicates that there is a moderate level of correlation between the dependent variable and the independent variable taken together. The *R* -square value indicates that, 1.4 % for self-mutilation score is contributed by the independent variable self-concept. This is also meant that the self-concept accounted in predicting the self-mutilation among the adolescents. The results indicate that there is a moderate positive correlation between the self-concept self-mutilation. Hence, hypothesis 3 .is accepted.

Figure 4: shows the Regression of social competence, emotional competence and self-mutilation by self-concept



The results have been displayed in figure 4 points out that the self-concept predicts self-mutilation at 1.4% levels.

The regression equation by figure 4, clearly substantiates for the hypothesis relating to the prediction of the dependent variable. The value of self-mutilation is found to be 1.4 at $P< 0.05$ level that is the maximum significance level. Hence, it is evident that the independent variables constantly contribute for the influencing prediction of the dependent variables self-mutilation.

DISCUSSION:

The results of present study seem to be successful in measuring the effect of self-concept on self-mutilation among the institutionalized and non-institutionalized adolescents. Developmental psychopathologists thus greatly emphasize that self-concept as a key domain of intensification for preventing problems and also for understanding and positive development (Masten, Best, & Garmezy, 1990).

The findings of the current investigation have brought out comprehensible and candid conclusion. . From the present study it is revealed that living in institutions minimizes the levels of self-concept and on the contrary non-institution living facilitates the growth of self-concept of the adolescents (Asbah & Razal, 2013; Millet et al., 1995).

In the present investigation interestingly, high and low self-concept groups remained similar with regard to their self-mutilation behaviour. Adolescents belong to both groups have moderate level of self-mutilation behaviour. It seems that, self-concept could not have any influencing role on self-mutilation behaviour of adolescents. Even the institutionalized and non-institutionalized background, could also show any significant variation on the self-mutilation behaviour of the adolescents studied. The institutionalized adolescents showed very minimum hike on the self-mutilation behaviour but not to the extent of significant variation. Hence, remaining either in institution or non-institution, the adolescents remain the same. Further, the adolescent boys and girls compared showed no difference between them on self-mutilation. This again suggests that, even the gender variation could not have any effect on the self-mutilation behaviour of the adolescents. The present study advocates that self-mutilation behaviour of the adolescents remains the same for all types of variations they have face in their life. The possible underlying principle could be understood that the adolescent period itself give the impression that may be inducing personal damaging behaviour. Erikson (1968) has opined that the adolescents pass through his or her life span, it is inevitable that, they will be experiencing certain amount of fluctuation between identity verses role confusion, which is the major psychological crisis any adolescents has to face. Hence, the homogeneity of the groups on self-mutilation may be the state of adolescent's contribution cutting across the institutionalization or non-institutionalization, the gender and the self-concept.

The view that certain amount of self-mutilating behaviour will be there for any adolescents have been supported by a host of researchers in this field (Perry & Herman, 1991; Strong, 1998; Tobin & Griffing 1996; Nixon, 2008; Morey, 2008; Yates, 2008; Matsumoto, 2008; De Leo, 2004; Cassandra, 2005; Pamela, et al., 2000; Rory et al., 2009; Julia & William, 2008; Ross & Heath, 2002; Carroll, et al., 1980). The finding on self-mutilation has obviously and bluntly establishes that, it is the usual and normal behaviour pattern observed among adolescents. And other variables studied in the investigation, such as, self-concept, types of institutions and gender could not elicit any types of impact on the self-mutilating behaviour of adolescents. It is to be highlighted that adequate care must be a great consideration among the institutionalized adolescents in enhancing, planning, recognizing that self-worth is a prime factor to annihilate other forms of behaviour. To boast greater competence in the adolescents, social skills training could be appropriate tool (Ashcroft, 2004). This would enhance the adolescents to have effective social interaction and competence skills that will influence students' academic success, career paths, life style and lifelong relationships with the society at large. One of the best ways to learn competence style and social skills is through role play with same age peers during the growing up process. To improve mutual interactions, class room and school environmental conditionings, this sort of instructions would be greater means among the adolescents (Erwin, 1994).

CONCLUSION:

- High levels of self-concept minimise the possibility of Self-mutilation among the adolescents.
- The self-mutilation behaviour found to be a common feature during the adolescents stage.
- Institutionalization and non-institutionalization initiate and shape different kinds of psychological characteristics of the adolescents.
- It could be concluded that self-concept has a moderating effect on the levels of self-mutilating behaviour among Institutionalized and Non-Institutionalized adolescent students.

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